The Times and Register.

Vol. XXIV, No. 4. NEW YORK AND PHILADELPHIA, JANUARY 23, 1892. Whole No. 698.

PAGE

ADDRESS.

VENESECTION; ITS REMEDIAL PROPERTIES. By B. H. Detwiler, M.D. - - - - 71

ORIGINAL ARTICLES.

THE MEDICAL PRACTICE LAWS AS CHANGED BY THE LEGISLATION OF 1891. By Henry A. Riley, A.B., LL.B. - - - - 73

OPHTHALMIA NEONATORUM AS A CAUSE OF BLINDNESS. By T. B. Schneideman, M.D. - - - - - - - - - - - - - - 75

SOME MOOTED POINTS CONCERNING THE VOMITING OF PREGNANCY. By T. Ridway Barker, M.D. - - - - - - - - - 78

CASE OF INVERSION OF A NON-PUERPERAL UTERUS. By John B. Roberts, M.D. - - 79

SOCIETY NOTES.

PHILADELPHIA COUNTY MEDICAL SOCIETY 80

Ophthalmia Neonatorum as a cause of Blindness. *Schneideman* - - - - - - 80

Some Mooted Points Concerning the Vomiting of Pregnancy. *Barker* - - - 82

Case of Inversion of a Non-Puerperal Uterus. *Roberts* - - - - - - - - - 82

NEW YORK ACADEMY OF MEDICINE - - - 83

Congenital Absence of a Portion of Both Lower Extremities. *Ridlon* - - - - - 83

Congenital Deformities of the Upper and Lower Extremities. *Myers* - - - - - 83

Postponed Discussion on Dr. J. E. Kelly's Paper on "The Anatomy of the Foot, with Exhibition of a New Club Shoe - - 83

PAGE

"A Consideration of some of the Affections of Tendon Sheaths and Bursæ, and their Relations to Injuries and Diseases of the Joints. *Whitman* - - - - - - - 84

Exhibition of an Improved Adjustable School Desk and Chair. *Hicks* - - - - 84

Tubercular Disease of the Vertebræ in its Early Stages. *Sayre* - - - - - - - - 85

THE CLINICAL SOCIETY OF MARYLAND - 86

Dust as a Causation Factor in Pulmonary Disease. *Mitchell* - - - - - - - - - 86

A Case of Elephantiasis Scroti. *Winslow* 86

MEDICAL AND SURGICAL SOCIETY, OF BALTIMORE - - - - - - - - - - - - 87

Twin Pregnancy with Placenta Prævia Centralis. *Brinton* - - - - - - - - - 87

Cephalic Version. *Gardner* - - - - - 87

Complete Recovery of the Case of Purpura Hæmorrhagica Rheumatica. *Brinton* - 88

THE POLYCLINIC.

COOPER HOSPITAL:

Chronic Corporeal Endometritis. *Godfrey* 88

EDITORIAL.

INFLUENZA - - - - - - - - - - - - - 89

ANNOTATIONS.

Scarlatina - - - - - - - - - - - - - 90

Baths in the River - - - - - - - - - - 90

Five Assistant Medical Inspectors - - - - 90

PAGE

LETTER TO THE EDITOR.

Influenza. *Baruch* - - - - - - - - - - 90

BOOK NOTICE.

Text-Book of Practical Anatomy. *Boenning* 90

THE MEDICAL DIGEST.

Bitten by a Snake. *Banerjee* - - - - - - 88

Strychnine in Spinal Paralysis. *Jacobi* - - 88

Chyluria Treated with Gallic Acid and Thymol. *Indian Med. Gazette* - - - - 88

Mortality Caused by Wild Animals. *Indian Med. Gazette* - - - - - - - - - - - 91

Cultivation of Cocaine. *Indian Med. Gazette* 91

Camphoric Acid in Phthisis and in Cystitis. 91

Improvements in the Manufacture of Aluminum. *Scientific American* - - - - - - 91

Influenza. *Lancet* - - - - - - - - - - 91

Detachment of Retina. *Bull* - - - - - - 92

Unsuspected Heart Disease. *Vickery* - - 92

GERMAN NOTES. *Marcus* - - - - - - - 94

Thilanin. *Saalfeld* - - - - - - - - - 94

A Case of Poisoning Through Dermatol. *Weismueller* - - - - - - - - - - - 94

Another Local Anæsthetic. *Staver* - - - 94

Diphtheria. *Radwansky* - - - - - - - 95

Local Anæsthesia. *Dobisch* - - - - - 95

Dermatol. *Von Rogner* - - - - - - - 95

MEDICAL NEWS AND MISCELLANY. 95

ARMY, NAVY, AND MARINE HOSPITAL SERVICE - - - - - - - - - - - - 96

NOTES AND ITEMS - - - - - - - - iv, vii

Address.

VENESECTION; ITS REMEDIAL PROPERTIES.[1]

BY B. H. DETWILER, M.D.

MR. PRESIDENT AND GENTLEMEN:—I shall present for your consideration to-day some observations on the subject of the abstraction of blood and its remedial properties. When I entered the practice of medicine bleeding was on the receding wave, and now on its return my experience and observation may be of service to the younger members of the profession. Preceding the advent of enteric fever there was a sthenic condition of system, and a tolerance to large abstraction of blood, and its abuse rendered the fallacy of Hahnemann possible. It was then dangerous to be sick, and the infinitesimal theory, assisted by the vis medicatrix naturæ, had better results than the heroic treatment of Rush and his followers. A friend gave me his experience while under the care of the late Dr. Dougal, of Milton, than whom there was no better exponent of the practice of medicine in the State. He had acute pleurisy. He was bled by his physician, followed by an emetic and large doses of calomel. He was bled again the next day, because the preceding bleeding showed a decided tendency to cupping—the contraction of the red corpuscles in the center of the vessel—a blister was then applied, and an additional calomel purge. Not improving, Dr. Dougal was called in in consultation; all was well, but the treatment was not sufficiently heroic, so he was bled freely and purged again with calomel. The blood standing showed the buffy coat, so was directed to bleed the next day to fainting, but when the next day came the wisdom of the course was questioned and bleeding was omitted, and when the doctor came his chagrin was evident, so he saw that he was bled freely and that he had a calomel purge. With ptyalism and blisters the pain subsided, and in time he recovered. At that time you can understand what the condition of the patient was, expressed by the statement, "the fever is broken, now if we can raise him, it will be all right." The patient was the Rev. Mr. Hudson, a frail, spare man, who spoke feelingly of his experience. Dr. Dougal was a firm believer in Rush, a strong man, his influence was felt and acknowledged by the profession in this entire valley. With the death-rate of enteric fever (my father and three uncles died with it), there appeared to be a change in the condition of the people, and the tolerance of bleedings. Finally bleeding was discontinued; veratrum, aconite and bromides displaced the lancet. In bleeding there were maxims; in an old work I find these:

1. Is the patient habituated to bleeding?
2. Is he too old or too young?
3. Is the season too hot or too cold?
4. Is the moon too new or too old?

When the patient's limbs feel heavy, when he has heat over the whole body, when the urine is thick and red, and when the pulse is fast and strong, bleed; when the patient is thin and under ten, or old, he should not be bled, and when the weather is too hot he should not be bled; also, the axiomatic dissertation upon the pulse was wonderful, and is no longer heeded. We do not note the fast, quick, bounding,

[1] Address delivered before the Clinton County Medical Society.

thready, weak, slow, strong and irregular varieties of the pulse and their indications as of old, but rely upon our clinical thermometers.

With instruments of precision there is no difficulty in caring for the sick intelligently, in comparison to the olden time. Yet at times we are at fault. A few days ago, a man suffering with la grippe was convalescing. I was called in hurriedly, and found him unconscious. He had congestion of the spinal cord and base of the brain. Free abstraction of blood, by cups, from the upper dorsal vertebræ, relieved him immediately. My first experience of the value of bleeding was by an old physician, when I was young in the profession. It was a case of proctitis with hemorrhoids. All was done that I could for my old friend, and the pain would not down. To my disgust, the doctor advised the lancet for the feeble old man; to my surprise, and the old man's comfort, as the blood flowed he was relieved; and to such an extent, that the tears coursed down his furrowed cheeks; his recovery was immediate. While I lost prestige, I gained knowledge. Facts are stubborn things: the frail, old man's tonic was the lancet. Eclampsia has been the exceptional complication of pregnancy that required bleeding under all circumstances. The accomplished Dr. Meigs was such an enthusiast in bleeding, that even after large loss of blood, when the patient would clasp her head, saying, "Oh, my head!" his advice was to bleed, and bleed largely. A short experience by the profession did not endorse it, and some sad cases resulted from it. Dr. Hiram Corson states that in his long life he bled all cases of eclampsia, and never lost one. My experience has not been so fortunate. I have bled largely and frequently in these cases, but only when the pulse was full and strong. I recall a case where I was called in consultation with the late Dr. Rittenhouse. It was a primipara. She was in convulsions. I bled her largely; the pulse still bounding, a second basin was filled; the tension relieved. Under anæsthesia, the child was delivered with the forceps. The recovery was rapid, without any untoward results. Another case; primipara; a frail woman with twins; the first child was born with use of instruments; before the second child was born, she had an eclampsic attack, which was relieved by delivering the child by grasping its feet. Her case was so critical that I stayed with her. During the night a second attack came on; instead of bleeding, removed a clot from the mouth of the womb. She made a rapid recovery. Had the last case been bled she would have died, and the arterial tension of the first case was so great there was danger of cerebral hemorrhage.

There are no iron-bound rules that regulate bleeding, but the general fitness of things. When Dr. Hiram Corson, the Nestor in medicine, states bleed in every case of eclampsia, he is wrong. Bleed only when the tension of the pulse requires it. The removal of the cause is good practice. If uræmic, bleeding is useless, beyond lowering the arterial tension to the point of safety. Dr. Burrell, in these cases, used benzoic acid, if he saw the case, even a few days before delivery, without, he claims, losing a case. Dr. Bedford quotes a case from St. Mary's, this State, in his inimitable work on obstetrics, where a practitioner had a case of eclampsia at the sixth month. The patient had eaten largely before bedtime of preserved quinces; an emetic relieved her. As I said before, the fitness of things must be observed. A free bleeding, in this case, would not have been good practice. Remove the cause, and effects will subside.

A child three or four years old, at a neighbor's playing, fell from an unprotected landing eight or ten feet on her head. She was picked up and carried across the street to her home, when she was laid on the lounge; she had a severe convulsion. I was sent for; a neighboring physician called in, who gave her chloroform by inhalation, when the convulsions subsided; left her saying that she would not recover. I saw her within a half hour, examined her carefully; her face was crimson, pulse imperceptible, another convulsion pending. There was no depression of the skull nor evidence of external injury; corded her arm; bled her freely, while she was in the second convulsion; as the blood flowed the convulsion subsided, the pulse came up, face became pale, and consciousness returned; bound up the arm; gave her a hypodermic of morphine; in the morning she was playing with her dolls, and in thirty-six hours was convalescent.

A man over fifty, an epileptic, subject to convulsions, was found unconscious, a physician was sent for, who found him passing from one convulsion to another without any apparent interval; the neighbors and family were awaiting his death. The veins of the head and face were as though corded; the skin livid, and the circulatory center overpowered. The case was critical, and three miles in the country. He corded the arm; had it held while he performed venesection with a razor. In a few minutes the tension was relieved, convulsions subsided, convalescence ensued and recovered; finally died in an epileptic convulsion. I mention these cases where the effect of venesection is immediate; not that gelseminum, bromides, chloral and chloroform should not be used, but that when there is a crisis the lancet should be used, and that a medical man's armamentarium is not complete without a lancet, or the knowledge when and how to use it. I will mention my first case of bleeding:

A farmer's wife wanted a tooth extracted, and a bleeding. I extracted the tooth boldly; but when I corded the great white arm without the sign of a vein I was nonplussed; but noticing a dim cicatrix over the median cephalic boldly plunged the lancet, was rewarded by having the office sprinkled with blood, and acknowledged that new doctors could bleed and pull a tooth. At a commencement in Baltimore the statement was made in the graduating address that should one of these young men believe that bleeding was necessary, he would see that it was not done under the endorsement of the institution that was now honoring them with a diploma. In my early practice I bled all my cases of pneumonia that were sthenic, not largely, but enough to free the right heart, then support with digitalis while blistering freely. There was not then the terrible fatality there is now in this disease. With the depression existing in la grippe I should bleed cautiously and early, if at all. There is a condition of system that you will meet, and which has given me much uneasiness and discomfort, congestive neurasthenia. It is a disease of middle life. The patients are well preserved, generally wakeful; have tender vertebræ, especially of dorsum, pain on pressure extending to the sternum, headache, aching of the eye-balls, pain passing from the back of the head to the eyes, irregular heart action, and impaired digestion. For this condition I have found useful a free abstraction of blood from the spine at the junction of the cervical and dorsal vertebræ, where the ganglion is located, which controls the inhibitory centers of circulation, digestion, and, to some extent, the respiration. By cupping I do

not refer to the equipment I formerly used, cups with an exhaust pump and scarificator, but an ordinary tumbler or goblet, and if no scarificator is at hand, and medical men know how necessary immediate action may be, a scalpel or razor with a vigorous application, ensures a free local venesection. I have frequently removed a pint of blood between the shoulders in a short time, with great relief.

I recall a prominent man from a neighboring county, large and plethoric, with a sense of heat so intense that in ordinary hot weather he could live only by the application of cold water to his head in his office and with wet cloths in his hat while in the sun; a free local depletion of the spine by cups relieved him, which was followed by large blistering of the spine. He is now carrying on a large lumber and mining operation with comfort.

You will notice that this neurasthenia is intensified by la grippe, which has the happy faculty of extending its skirmish lines and locating in all the weak places in the economy, especially favoring these spinal neuroses.

A few days ago, I was called in to see an old man, retired from business, doing nothing—was hurriedly summoned to see him—found him with the anxious expression of angina, intense pain, with the fixed chest walls indrawn, inability of inspiration; his family around him, expecting his immediate death. I gave him a hypodermic of the tablets made by Frazer & Co., N. Y., called Bromide, No. 2.; morphine hydrobromate, $\frac{1}{16}$; hyoscine, $\frac{1}{200}$; monobromide of camphor, ½; which quieted the intensity of the pain, without nausea. The application of a goblet as a cup over the spine, scarified with a razor, gave immediate relief, followed by blistering of the spine; case recovered promptly.

I mention the case as it was unpromising from the age of the patient, his feebleness, and the intense character of the invasion.

I find this anodyne is tolerated by all these neurasthenics that can not use morphine. The monobromide is not soluble in water, so dissolve the tablet, have the patient swallow the insoluble camphor and use the clear solution hypodermically. There is a form of rheumatism graphically described by the late Dr. Meigs—gouty, with tender spinal vertebræ, that is exceedingly intense, that yields readily to the application of cups to the lumbar spinal vertebræ.

In this conversation, I will not speak of the pathological changes of the blood, nor the chemical action of remedial agents, but simply give observations and experience of an active life in a period when it was not fashionable to bleed, presuming that actual facts will be more acceptable than theories, and will close with an extract from a lecture of Dr. Pepper to his class a few days ago:

"I may just say here that venesection is not practised as much at the present day as it should be. There is no doubt that many persons may be brought through the crisis of certain diseases who otherwise would die. There was a time when venesection was carried to an extreme, and, no doubt, with bad results; but I am safe in saying we are as far to the opposite extreme at the present day, and as serious results follow the one extreme as the other. In a great many colleges, venesection is not taught at all. The question that concerns us is when to bleed."

A Pittsburgh dentist anæsthetized a patient with "vitalized air," which unfortunately devitalized the man.

Original Articles.

THE MEDICAL PRACTICE LAWS AS CHANGED BY THE LEGISLATION OF 1891.

By HENRY A. RILEY, A.B., LL.B.,
NEW YORK.

THE medical practice laws of several of the States were amended by the legislatures holding sessions in 1891, and, in two or three, statutes were enacted providing for new methods of examination and licensing. In several others, bills were presented and strongly urged, but failed of passage, for one reason or another. It is interesting to note the general desire manifested by the profession and by the public at large to place proper safeguards about the entrance into medical practice, and it will not be long, probably, before most of the States will require an examination in addition to a diploma, in order to enable a person to obtain a license to practice; or, if this is stating the case a little too strongly, it will not be long before there will be State Examining Boards for all persons not graduates of medical colleges in good standing. At present, there are no laws on the subject in Connecticut, Kansas, Maine, Massachusetts, Rhode Island and Utah, but bills have been prepared in several of these States, and will be presented to the legislatures when they convene. In Maryland and Ohio, the laws are practically imperative. It will be of interest to examine what new legislation was passed in 1891, and in what regards the old laws were changed.

Perhaps the most important of the new laws was that enacted in Nebraska. In this State acts were passed in 1881 and 1883, but they did not go further than to secure a registration in the office of the County Clerk, upon requirements which were not sufficient to prevent many incompetent and unfit persons from practising medicine. These laws required the applicant to present to the Clerk of the County in which he resided a statement that he was a graduate of a legally chartered medical college, or had practised ten years, the last two of which had been in Nebraska, or had attended one full course of lectures and practised three years, the last of which had been in Nebraska, or had passed a satisfactory examination before the medical board of some other State.

The County Clerks were naturally not qualified for examining into the standing of medical colleges, and no special duty seems to have been required of them in regard to registration, except to take the statement furnished by the applicant.

The new law, however, was one regulating generally the practice of medicine, and its provisions were as follows:

A State Board of Health was established, consisting of the Governor, Attorney-General, and the Superintendent of Public Instruction. The board was to have four secretaries—two from the allopathic school, one from the homœopathic and one from the eclectic. It was declared to be unlawful for any one to practise medicine, surgery, or obstetrics, who had not obtained a certificate and had it registered in the county where he resided. This certificate was to be issued by the State Board of Health, and only to a graduate of a legally chartered medical school or college in good standing. A physician residing in another State could, however, be called in consultation by a resident physician who had complied with the law.

The term "medical school or college in good standing" was defined as follows:

"A medical school or college requiring a preliminary examination for admission to its course of study, and which requires as requisite for the granting of the degree of M.D. attendance on at least three courses of lectures, of six months each, no two of said courses to be held within one year, and have a full faculty of professors in all the different branches of medical education, to wit: anatomy, physiology, chemistry, toxicology, pathology, hygiene, materia medica, therapeutics, obstetrics, gynecology, principles and practice of medicine and surgery, and clinical instruction in the last two named."

This requirement as to three courses of lectures was not to apply, however, to diplomas granted prior to July, 1891.

The applicant was to present the diploma of such a college with an affidavit that he was the lawful holder, and if found genuine the certificate or license to practice was to be issued.

Physicians now in practice were required to present their diplomas within six months, and, if regular, certificates were to be granted.

The board could refuse to grant a certificate to any one guilty of unprofessional or dishonorable conduct, and could revoke one already issued.

Any one practising without a certificate was guilty of a misdemeanor, and could be punished by a fine of not less than $50, and not more than $300, with costs, and was to be committed until the fine was paid. In addition, there could be no recovery in a civil suit for any medical services.

A provision which has been said to have a bearing on the Christian Scientists was that which provides that any person shall be regarded as practising medicine who shall operate, or profess to heal, or prescribe, or otherwise treat any physical or mental ailment of another. Exceptions were made, however, in the case of United States army and navy medical officers, nurses, and those who administer in their families ordinary household remedies, or who render gratuitous services in cases of emergency.

The sellers of nostrums, whom the writer has often seen in the streets of Nebraska towns, disposing of their wares from carriages, by the light of flaming torches, were disposed of by a provision which says "that any itinerant vendor of any drug, nostrum, ointment, or appliance of any kind intended for the treatment of any disease or injury, or who shall by writing, printing, or any other method, publicly profess to cure or treat disease, or injury, or deformity, is guilty of a misdemeanor, and may be punished by a fine not exceeding $100, or imprisonment in the county jail for a period not longer than three months, or by both."

South Dakota passed a general law regulating medical practice, the main provisions of which are as follows:

No person is allowed to practice who is not a graduate of a lawful medical college, or who is an habitual drunkard or a man of bad moral character.

If the applicant presents a proper diploma, or if lost, a certified copy with a fee of $5, he receives from the Superintendent of the Board of Public Health a license, which shall be recorded in the office of the Register of Deeds of the county where he resides.

Any person practising without complying with the law, is guilty of a misdemeanor, and practising medicine within the meaning of the law means those who shall profess publicly to be physicians, and to prescribe for the sick, or who append to their names the letters M.D.; but this section does not apply to students who prescribe under the supervision of their preceptors, nor to commissioned surgeons of the United States army and navy, and does not prevent gratuitous services in cases of an emergency.

The law also makes it a misdemeanor to fail to report to the County Health Superintendent the existence of contagious or infectious disease, or to conceal such cases, either among persons or animals.

The law does not apply to persons now in the lawful practice of medicine, surgery or obstetrics.

If a license is fraudulently obtained, or if the holder is an habitual drunkard, or guilty of immoral practices or of gross professional misconduct, the license may be revoked, but the offender has the right of appeal to the Circuit Court of the county.

It will be noticed that the laws of both Nebraska and South Dakota are in line with the best legislation on the subject, and make no provision for the licensing of persons not graduates of medical schools.

In Oregon a law was passed in 1889 granting certificates on diplomas issued by legally chartered medical institutions in good standing, of whatever school or system of medicines, or on examination in the case of non-graduates or licentiates by the State Board of Medical Examiners.

This law was amended in some particulars by the law of 1891. Two forms of certificates had been provided, one for holders of diplomas or licenses, and one for candidates examined by the Board; a third was added for those who had registered in conformity with the law of 1889. This latter class consisted of all who were in active practice in 1889, and who should register their names in a book provided by the County Clerk within six months. It was further provided that there was nothing to authorize the Board of Health to make any discrimination against the holders of genuine licenses or diplomas under any school or system of medicine in good standing.

Those practitioners who have registered their names with the County Clerk, under the law of 1889, are required to produce a certificate to that effect within ninety days, and the State Board shall then issue a certificate mentioned above as the third form.

An important amendment to Section 5 of the law of 1889 was made, which in the hands of a Tax Board of Examiners, might, perhaps, lower the requirements for practice.

The original section provided that examinations of persons not graduates or licentiates were to be made by the Board, and the amendment was to the effect that the examinations were to be in whole or in part in writing and of an elementary and practical character, but sufficiently strict to the qualifications of the candidate as a practitioner. The fee for the examination was fixed at $10.

In Indiana, South Carolina Tennessee andNew York, there were also amendments made to the laws in force. In Indiana, the law of 1885 required the practitioner to procure from the Clerk of the county where he intended to practice a certificate which was based on a diploma of a reputable medical college, or a practice of ten years without a diploma, or a practice of three years and an attendance upon one full course of lectures.

This law was amended so that it was not made necessary to furnish such proof when a practitioner moved to a different county, but allowed him to file his license in the county of his new residence and attain another license thereon. A book of such licenses was to be kept as a public record.

In South Carolina, the law of 1888 provided for the appointment of a Board of Examiners, consist-

ing of five physicians, to whom should be presented all diplomas for examination, and the Board was authorized, at their discretion, either to issue a license thereon or to examine the applicant further. The Legislature of 1891 passed an act which it is somewhat difficult to reconcile with the previous law.

The law provides that all physicians who shall engage in the practice of medicine or surgery, shall, before doing so, submit their diplomas to a Board consisting of three reputable physicians in each county, said Board to be appointed by the Governor, upon the recommendation of the medical society of the county, where such society exists, and in those counties where no medical societies exist, then upon the recommendation of the Senator and member of the House of Representatives from such county.

The 1891 law does not repeal the law of 1888, or refer to it in any way.

In Tennessee, the right to practice medicine depends upon registration in the office of the County Court Clerk, of a certificate issued by the State Board of Examiners, and based either upon the diploma from a college in good standing or an examination by the Board. This law, which was passed in 1889, was amended in several particulars at the session of 1891. The original law required persons in actual practice at the time of the passage of the act to register their certificates within six months, but this period was extended by amendment to July 1, 1891.

The 1889 law provided that a person wishing to begin practice after the passage of the law should be examined or present a diploma from "some medical college in good standing, and said Board shall recognize any college that is recognized by the National Medical Association."

This provision was changed so as to make the State Board of Examiners the judge of the "good standing" of the medical college instead of the National Medical Association.

Section 13 of the 1889 law was amended in several particulars, and now reads as follows: "That it shall be unlawful for any itinerant physician or vendor of any drug, nostrum, ointment, or appliance of any kind intended for the treatment of disease or injury, to sell or apply the same; or for such itinerant physician or vendor by writing, printing or other methods to profess to cure or treat disease or deformity by any drug, nostrum, manipulation, or other expedient in this State, and that whoever shall violate the provisions of this section of this act, provided this act does not apply to merchants or druggists, shall be guilty of a misdemeanor, and upon conviction thereof before a court of competent jurisdiction shall be fined in any sum not less than $100 and not exceeding $400; *Provided*, That veterinary surgeons and stock doctors be not included in this act."

Section 14 of the old law provides that any person who shall practice medicine or surgery without the certificate of the Board of Examiners, shall be liable to a fine of $25 for the first offence and $200 for each subsequent offence. This is now amended to the very verge of leniency, so far as the fine is concerned; but the offence is made a misdemeanor. The fine is now a sum not less than $10 and not more than $25.

The Secretary of the Board of Medical Examiners, Dr. T. J. Happel, in his report, made in April, 1890, recommended the change, placing the power of judging as to the standing of medical colleges in the hands of the Board.

He also stated that there were three thousand two hundred and sixty-one practitioners in the State holding certificates, and that there were many persons who had not registered. It was probably to allow a further day of grace to this class that date of compliance with the law was extended to July 1, 1891.

In New York, a law was passed in 1890, requiring, after September 1, 1891, an attendance upon three courses of lectures, and an examination before the State Board of Medical Examiners to entitle a person to practice within the State. This was amended in 1891, so as not to apply to students who had duly matriculated in some legally incorporated medical college of the State of New York before June 5, 1890, provided proof of such matriculation was filed by the Secretary of the College with the Secretary of the Board of Regents of the University within three months.

It will be seen that this body of legislation is of importance to the profession, and it is quite likely that even a larger amount will be placed on the statute books in 1892.

OPHTHALMIA NEONATORUM AS A CAUSE OF BLINDNESS.[1]

By T. B. SCHNEIDEMAN, M.D.

MY object in bringing this subject before the Society is to direct attention to a disease which is responsible for about one-third of all cases of blindness, of which a most important means of prevention—that of public legislation—can only be obtained by the active intervention of medical societies. The following case is presented, not because of its novelty, unfortunately, but as somewhat typically, representing the lamentable result of negligence or ignorance.

H. M., aged three. Both eyes became sore when five days old. O. D.: Dense adherent leucoma lower inner portion of cornea. Remainder of cornea hazy, stretched blue-gray iris in contact with it. Globe apparently somewhat distended; leucoma prominent, but easily covered by lids. T.: Normal. O. S.: Leucoma slightly denser and more prominent, but not larger. Broader space of translucent cornea than O. D. R., and L. light perception.

The subject has been very thoroughly worked out in Europe, and a mass of statistics has been accumulated. According to the report of the Royal Commission on the Blind, published in 1889, 30 per cent. of the inmates of the institution, and 7,000 persons in the United Kingdom, have lost their sight from this cause. Professor Magnus, of Breslau, finds that no less than 72 per cent. of all who become blind during the first year of life are rendered so by purulent ophthalmia; and even of those who become blind before the twentieth year of life, it constitutes as much as 23.50 per cent. Looking at the subject in another way, he shows that of 10,000 children under five years of age, 4.28 are blinded by purulent ophthalmia. In the blind asylums of Switzerland the proportion who have lost their sight from this disease is 26 per cent.; in the asylums of Austria, Hungary, and Italy, about 20 per cent.; while in Spain and Belgium it falls to about 11 or 12 per cent. And in this city Dr. Harlan, as the result of examination of the eyes of 167 inmates of the Pennsylvania Institution for the Blind, found that 55 owed the affliction to purulent ophthalmia, and more than half of these were of the form occurring in infants.

The lesson taught by such statistics is not simply that ophthalmia of the newborn is the most common

[1] Read at the Philadelphia County Medical Society, December 23, 1891. For discussion see page 80.

cause of blindness; if that were all, they would, no doubt, still preserve a melancholy interest; but they have a much greater importance, for they tell us that it is quite within our power to have prevented the great affliction of blindness in one-third of those who are deprived of sight. For it is hardly too much to say that no one should lose his sight from this disease; not only because it is quite amenable to treatment, if this be instituted from the beginning, but because the disease itself can be prevented in most instances if those who have the care of mother and child understand the nature of this affection.

Ophthalmia of the newborn is an *infectious* disease, and can only occur after the infectious matter has come into actual and somewhat prolonged contact with the conjunctiva. The noxious matter is in every instance derived from an inflamed vagina (or urethra), or from another eye. In the great majority of cases infection takes place from the vagina, and it is to be remembered that the disease is not caused by the secretion of a specific (gonorrhœal) catarrh only, but that it may be produced by the secretion of a simple leucorrhœa, or, at least, by what is recognized as such clinically.

As regards the period when infection occurs, this may take place either during or immediately after birth, or at some subsequent moment. In the former case, the *materies morbi* is derived directly from the vaginal secretion. The child passes through the parturient canal with closed eyes; hence, during the passage of the head the secretion can only penetrate into the conjunctival sac in very small amounts, if at all; but it remains adherent to the eyelashes and edges of the lids, and can readily gain an entrance into the eyes as soon as these are opened, and the child winks upon the escape of the head. Infection may take place during birth, if anything occurs to displace the soft parts of the face, as may happen in protracted and difficult labors, large size of head, etc., conditions more likely to be present in primiparæ, and with the large heads of male children. But the time most fraught with danger is usually the moment the head escapes and the child first opens its eyes. In the majority of cases infection takes place at some time during labor, and the disease first manifests itself from the second to the fifth day; if it does not appear until later, infection took place subsequent to birth. This may happen by the transference of secretion to the child's eyes in various ways, as by the hands of the attendant, by soiled linen or sponges, etc.; but the lochial discharge, as such, has been found to be incapable of causing the affection, if the woman be free from disease.

The discovery of the gonococcus has led investigators to examine the secretion of purulent ophthalmia for the same organism, and in the vast majority of cases examined it has been found to be present therein also; still, different observers appear to have reached results not entirely in accordance as to the relative frequency with which this organism is present. Cases do occur in which it cannot be found. Hence, the attempt has been made from a bacteriological point of view to recognize different forms of the disease—a specific form and simple inflammatory forms. As stated above, the secretion of simple vaginal catarrhs are capable of causing purulent ophthalmia.

Formerly this disease was attributed to a variety of causes, such as injuries received by the eyes during birth, icterus, chilling of the body, intense light, etc., but these views are, of course, no longer entertained. Ordinary pus and even decomposed pus cannot produce it. Purulent secretions from lachrymal abscess and caries of the orbit frequently get into the eye, and do produce inflammation of the conjunctiva; but not the ophthalmia of the newborn, with its great liability to involvement of the cornea. Putrid flesh, putrid blood, and even pure cultivations of various micro-organisms, have been introduced into the conjunctival sac without any ill effect.

Prophylaxis to be efficient must, of course, first of all recognize the infectious nature of this affection, and secondly, the source whence the infectious matter may be derived.

Among general measures are to be placed all influences which can be employed to impress upon the public the dangerous character of all affections of the eyes of young children. Like all similar diseases, this affection is most prevalent and destructive among the poorer classes, who do not usually employ a physician to attend them in confinement, but rely upon a midwife, too often but little better instructed than the woman she attends.

In some dispensaries for the treatment of diseases of children, a small tract is handed the mother or attendant who brings the child, giving advice as to the proper care of infants, their diet, bathing, etc. A few lines might be added calling attention to the serious nature of this inflammation—ignorance of which and the proneness to ascribe every affection to "catching cold," which will get well of itself, is responsible for many ruined eyes. With this end in view, it might be advisable to have articles appear in the public prints from time to time explaining the danger of the disease in question, and urging the importance of immediately attending to every case of inflammation of the eyes of the young child. Even the ignorant classes understand the dangerous nature of certain other diseases, such, for example, as diphtheria and scarlet fever, and if ophthalmia of the newborn could be added to these, the deplorable results of neglected cases would be less frequently observed.

To reach this class (which is undoubtedly responsible for the great majority of those unfortunates who have become blind from this disease, namely, midwives), it has been proposed to compel all such to report every case of ocular inflammation at the earliest possible moment to some physician. Such laws are in force in certain countries of Europe, and there appears no good reason why a similar law might not be enforced in this country, just as there are laws requiring other contagious diseases to be reported. If this could be done with any degree of efficiency, it would do more toward abolishing loss of sight from this cause than any other measure. The State of New York has such an act in operation, requiring midwives and nurses to report every case of inflamed or reddened eyes occurring within two weeks after birth, to some legally qualified practitioner within six hours, under penalty of a fine or imprisonment, or both. This law has been in operation for a little more than a year, and it is hence too early to obtain much information as to its practical working. A few convictions would direct the attention of that class which it is desired to reach, to this subject, and in this way, at least, be productive of a certain amount of good.

As regards special measures of prophylaxis, these were clearly formulated as early as 1807, by Gibson, in the following principles, which all later experience has tended to confirm. They are, first, to cure the leucorrhœa of every pregnant woman when possible; or failing in this, second, to disinfect the vagina during labor; and third, to remove the secretion from

the child's eyes immediately after birth by a fluid which renders the secretion harmless.

Notwithstanding their importance, I shall here pass over the first two and consider briefly the third of these indications. Of all the methods employed, none have yielded better results than the one recommended by Credé. This consists in dropping into the eye, a two per cent. solution of nitrate of silver, after simple preliminary washing with clean water. Other agents, such as carbolic acid and boracic acid, have been tried, but none gave results so satisfactory as the silver, perhaps because the latter has the power of penetrating deeper into the tissues. As a proof of the efficacy of this procedure in diminishing the number of cases of purulent opthalmia of the newborn, the following figures, all obtained from the same hospital and the same attendants, furnish the evidence:

Children.	Treatment.	Per ct. of blenorr.	Per ct. of catarrh.	Total.
1092	No treatment	4.75	14.5	19.25
1541	2 per ct. of carbolic acid.	1.42	6.	7.42
1250	2 per ct. of silver nitrate.	0.72	4.72	5.44

And similar good results have been obtained in other lying-in hospitals. Still, this method, which is somewhat severe, is not necessary in every case in private practice, although, even if unnecessary, it is quite devoid of serious danger. As a milder measure, simple washing the eyes with clean water as soon as the child is born, has been found efficient in diminishing the number of cases of the disease—while in any case in which there is a history of copious purulent discharge from the vagina, it would be advisable to employ the silver solution as recommended by Credè.

As regards the disease itself, it is almost superfluous to present any formal description; its phenomena are so characteristic that it is impossible to mistake its nature when fully developed. The swollen and reddened eyelids, the upper drooping and partially overlying the lower, the great difficult or even impossibility of opening the eyes, the profuse purulent discharge welling forth as the lids are gently separated by the finger, the pain and heat, the swollen conjunctiva, rising like a mound, in which the cornea is buried, all these go to make up a picture which cannot be overlooked nor confound it with any other. But that every inflammation however slight, affecting the eyes of a newborn child may, if neglected, become the fully developed disease, and that, too, in a day or two, should always be in the mind of every one who has any connection with the case.

The danger of this disease consists, of course, in the great liability of implication of the cornea, leading to perforation of this structure, with the serious results dependent thereon. It was formerly believed that the cornea, being an avascular structure, became affected from interference with its nutrition by the pressure of the swollen conjunctiva; but while such pressure may be unfavorable to the nutrition of this structure, and predispose it to yield more readily, the direct cause of the corneal disease is infection from the micro-organisms which have their nidus in the profuse purulent secretion, upon the recognition of which depends the rational and efficient treatment of this disease. This consists, first of all, in the removal of the pus from the conjunctival sac as soon after it is secreted as possible; and second, to render innocuous any portion of the secretion which remains in the eyes by appropriate germicides; and thirdly, to act upon the inflamed secreting membrane by some agent capable of modifying this surface and checking or diminishing its secretory activity for the time being.

The particular means adapted to carry out these indications are various, and the methods selected vary somewhat according to the preferences of different physicians. To disinfect the conjunctival sac almost all the antiseptics employed in general surgery have been used, and with more or less good effect. The following plan has been found so efficient as to leave little to be desired: The attendant should remove the pus once every hour during the height of the disease; this can be done by gently separating the lids and flooding the conjunctival sac repeatedly with an ordinary pipette or dropper until the cleansing fluid returns clear and unmixed with pus. The fluid employed is a rather strong solution of bichloride of mercury, 1 : 2,000. Besides its mechanical effect in flushing the sac, and so removing the pus, it is one of the best germicides that can be employed, and withal entirely safe. Other agents might be made use of, such as carbolic acid in 2 per cent. solution, saturated solutions of boracic acid, though the latter seems inert as a germ destroyer (at least, according to laboratory experiments), nitrate of silver, etc., but none of these agents have any advantage over the bichloride. To meet the third indication, to modify the inflamed membrane, a rather strong solution of nitrate of silver (10, 20, or even 40 grains to the ounce) should be applied once, or perhaps twice, in the twenty-four hours to the everted lids by the surgeon. The application can be readily made by wrapping a pledget of absorbent cotton around a match stick, dipping into the silver solution until saturated, and then gently and thoroughly applying it to the palpebral conjunctiva. No subsequent washing with sodium chloride solution is necessary. The above treatment, simple as it is, gives results entirely satisfactory. I do not recall a single case in which it was practised that did not result in perfect recovery without damage to the cornea, although in some cases the disease has existed for a number of days, and in a number of instances the cornea was so greatly infiltrated when the patient first came under treatment as to cause fears of immediate perforation. In those cases in which the cornea becomes affected, as evidenced by partial opacity, atropine, or, in some cases, eserine, should be instilled into the eye; for if, unhappily, perforation should occur, the eye will be more likely to preserve some degree of useful vision, if prolapse of the iris can be avoided.

If one eye only is affected, the question arises how to prevent infection of the other eye. The shield to protect the sound eye is not applicable in infants as it is in adults. Great cleanliness, constant removal of the secretion, making the child lie on the affected side, will prevent infection in many cases. It might also be advisable to use the bichloride or the silver solution as a prophylactic measure.

Finally, in those cases in which perforation, with its usual results of adherent iris, etc., has occurred, something may be done by operative interference if any portion of the cornea remains clear. Here the indications are to free the iris from its adhesions to the cornea lest total staphyloma supervene. This procedure may be difficult to carry out, may involve extraction of the lens, and, in any case, would hardly give more than perception of very large objects.

Dr. L. Webster Fox will lecture at the Franklin Institute, January 29, on "Eyesight, in middle life and old age, with a few hints for its care and prevention." The lecture will be illustrated.

SOME MOOTED POINTS CONCERNING THE VOMITING OF PREGNANCY.[1]

By T. RIDGWAY BARKER, M.D.,
Demonstrator of Obstetrics in the Medico-Chirurgical College, Philadelphia; Out-Door Obstetrician to the Penn Dispensary.

IN discussing the etiology, symptomatology, and prognosis of the digestive disturbance associated with gestation known as morning sickness, or the vomiting of pregnancy, it becomes necessary at the very outset of a comprehensive study of the subject to exclude those forms of gastric trouble which, while often accompanying this purely physiological process, are nevertheless not dependent upon it for their existence, but upon some pre-existing morbid condition which is simply aggravated by the changes incident to gestation.

From a failure to appreciate and differentiate between these forms of gastric disturbance is largely due the confusion and misconception which is so general, hence the existence of such a multitude of views as to the cause and gravity of the vomiting of pregnancy.

It becomes necessary, therefore, that we state clearly that when we speak of morning sickness we do not include the so-called vomiting *in* pregnancy, but confine our remarks solely to the vomiting of pregnancy. Without further explanatory remarks, let us proceed to a consideration of the subject from a scientific standpoint, ever mindful, however, how easy it is to advance a theory and how difficult to find evidence to support it. That the occurrence of vomiting without apparent cause in females who have exposed themselves to the risk of conception is a sign of much importance is generally admitted, since it so quickly follows cessation of menstruation, and, therefore, further tends to confirm the presumptive evidence of pregnancy. With reference to its etiology, one finds as many views as there are stars in the sky, each differing from the other in magnitude and brilliancy even as these distant orbs of light. Let us then turn away from such a merry-go-round of medical opinion and seek to discover the truth in the realms of anatomy and physiology rather than in the domain of idle speculation.

Coincident with conception, we find a general rise in the intra-pelvic blood pressure resulting in increased activity on the part of all the viscera therein contained, which are concerned in the process of reproduction. Cells heretofore carrying on a passive existence now spring into a high state of activity. Likewise there occurs hyperplasia and hypertrophy of tissue which is especially rapid in the uterine muscular elements. Nerves, which in the unimpregnated condition possess but a low grade of sensibility, now become highly sensitive and transmit readily to their respective centers slight disturbances which, under other circumstances, would fail to throw them into a state of activity. What relation, one may very properly ask, exists between the vomiting of pregnancy and this exaltation of the nervous system? A causal one, most assuredly!

Can one fail to realize that this is a symptom of pregnancy due to the change in the nervous equilibrium induced by the process of gestation? Surely not. Rather are the nausea and vomiting expressions of a reflex irritation having its origin at the end-organs of the uterine nerves which, as we have seen, are in a hyperæsthetic state. As the growing ovum demands, day by day, an increased space for its development, these end-organs are subjected to a varying degree of irritation which is transmitted to the centers and thence reflected out along the nerve-filaments distributed to the stomach. Why this affection is of more frequent occurrence and of greater severity in the first than in subsequent pregnancies, one can readily understand by comparing the cavities of the primiparous and multiparous organs.

We find in the former that the uterine muscular walls are convex and nearly, if not quite, in apposition, hence the capacity of the organ in these females is relatively less. Not so the multiparous uterus, for its walls are concave and the capacity is further increased in length by one-half of an inch, owing to incomplete involution on the part of nature after the first pregnancy. Need we seek for more conclusive evidence than this to support our position? Is it not plain to be seen that the resistance in the primiparous organ will be greater and the nervous disturbance more pronounced than where the cavity is larger, thus allowing the ovum to undergo its development without interference? Further, the period when nausea and vomiting are most apt to occur is in the second month, at a time when the growth of the uterus is principally lateral and the villi of the chorion are thrusting themselves into the serotine or placental decidua. As to the character of its onset, it is usually gradual and disappears in a similar manner as the uterus rises out of the true pelvic cavity, thus having quite ceased by the end of the fourth month.

Concerning the symptomatology of this affection, it has not a few well defined characteristics. The primary nausea and oppression experience over the epigastrium soon give place to vomiting, not, however, preceded or accompanied by any degree of nervous depression as is the case with emesis under all other circumstances. The food, if any is present in the stomach, is expelled, not violently nor with any amount of retching, but almost as if it were regurgitated. Should the stomach be empty, then simply a little clear, normal gastric mucus is raised, which, as it usually occurs early in the morning, has given rise to the popular appellation of morning sickness. Further, if the matter vomited be food, it will not be found on examination to be sour or to have undergone decomposition, but in a more or less perfectly digested state, depending upon the length of time since its ingestion. As to the subsequent amount of nervous depression, in most instances it is practically *nil*, even when the vomiting is frequent and of long duration. This fact is very noticeable in some cases; the pregnant female may have just finished a hearty meal—for impairment of the appetite is rather the exception than the rule—when almost immediately afterward she will be obliged to evacuate the stomach, only to turn to the piano and find consolation for her lost breakfast. Rarely does one meet with a case of vomiting of pregnancy where the female's health has materially suffered, and this is what one would reasonably expect from a study of the symptomatology of the affection.

That this digestive disturbance is a purely sympathetic one is proven by the fact that by a strong effort of the will the female can not infrequently ward off an attack.

Should she, for instance, have accepted an invitation out to dine during this period of gestation, she can control the nervous irritability by a firm determination not to betray her condition to the assembled guests. It has been repeatedly asked, How can a woman suffer from morning sickness at one period of gestation and not at another? in other words, How is it that the attacks vary in severity in different preg-

[1] Read at the Philadelphia County Medical Society, December 23, 1891. For discussion, see page 82.

nancies? Moreover, why is it that one pregnant woman has morning sickness and another does not? Can this be explained on the hypothesis of reflex nervous irritability? Most assuredly!

The variability in the duration and severity of the affection is due to two factors: Greater or less irritation, and greater or less irritability. The question may be asked, Is vomiting of pregnancy a physiological or pathological process?

It has been stated that among women of a strong, robust type, vomiting of pregnancy is exceptional rather than the rule, as is the case in Europe and America. But this fact has no direct bearing on the case; it goes without saying, that the stronger and less sensitive the nervous system, the less general and severe will be the sympathetic disturbance. One certainly is not warranted in stating that the vomiting of pregnancy is a pathological process, for it is due to a purely physiological cause. There exists no morbid alteration in structure or function of the nerves. The irritability is not pathological but physiological, depending upon the degree of sensibility of the nervous apparatus. Yet it has been claimed by some investigators that this very exaltation is evidence of some pathological lesion. Surely not. It were, it seems to me, as reasonable to declare a person's brain diseased because he is irritated by Wagner's music, in which he finds no harmony, as to declare that the sympathetic disturbance excited by pregnancy is due to some morbid process.

Again, if we select two galvanometers, one registering the weakest electric current, the other, equally well constructed, but less sensitive, we cannot say that the former is any more perfect than the latter; they differ simply in the degree of their sensibility. Difference in sensibility within certain prescribed limits is a physiological, not a pathological fact. While vomiting, as Austin Flint points out, is not, strictly speaking, a physiological process, yet under these circumstances, it is far from pathological; rather let us say it is the pathological expression of a physiological process. The vomiting of pregnancy, unless complicated by some morbid process, never gives rise to alarming symptoms or threatens life. If prolonged beyond the period of quickening, its continuance may be accepted as positive evidence of some complication which a decided alteration in the character of the vomited matter will usually indicate.

Cases of pernicious vomiting call for diligent search for organic lesions in the nervous system or structural changes in some of the generative or associated organs. That the vomiting of pregnancy occurs in healthy, strong women almost as frequently as in their less robust sisters, though in a milder form and of shorter duration, only confirms the view as to its physiological nature.

The view advanced, that the difficulties of parturition are proportionate to the severity and length of the morning sickness, one is scarcely prepared to accept. The gravity of the digestive disturbance is to be estimated by the amount of nervous irritability, while the difficulties attending parturition may be classified under two heads: maternal and fœtal. The former including uterine inertia, pelvic deformity, and rigidity of the soft parts; the latter, abnormal size of the fœtus and malpositions of the fœtus. Surely no such conclusions are justified, for the reports from the large lying-in hospitals of both America and Europe, unmistakably prove no such relation exists. Females who have suffered great annoyance from morning sickness have frequently as easy and sometimes more rapid labors than those who have almost wholly escaped this unpleasant early indication of pregnancy. Therefore, in conclusion, it would appear from a study of this affection:

1. That the vomiting of pregnancy is due to a reflex irritation produced by the developing ovum acting upon an exalted nervous system.
2. That it is not an affection of great gravity and need occasion no anxiety or alarm.
3. That active treatment is rarely demanded, as it is only a disturbance of a few weeks at the most.
4. That the severity of the gastric trouble is no indication of the character of the subsequent labor.
5. That where the affection persists beyond the period of quickening, it is due to pathological causes which must be discovered and treated accordingly.

CASE OF INVERSION OF A NON-PUERPERAL UTERUS.[1]

By JOHN B. ROBERTS, M.D.,
Professor of Surgery in the Woman's Medical College, of Pennsylvania.

THIS case seems to me of interest because of the comparative rarity of the condition. I give it simply as a contribution for clinical discussion.

Mrs. H., aged forty three, in November, 1890, complained of having had bearing-down pain for some months, and a slight vaginal discharge, which had recently become offensive. Menstruation had been regular, and there was no great loss of blood at her usual periods. The woman had been married eight years; had had one miscarriage, but no children.

Vaginal examination revealed a reddish mass protruding from the uterus through a well-dilated os. As this was evidently a sub-mucous fibroid tumor, a drachm of fluid extract of ergot was ordered to be taken three times a day, and douches of corrosive sublimate (1 : 4,000) to be used twice daily. A little later the vaginal douche was changed to carbolic acid solution.

About ten days after I first saw her the patient was etherized, and a sloughing, friable mass removed with the fingers and forceps, aided by a curette. The mass was about the size of a small orange. The patient recovered promptly, and was discharged from treatment in about two weeks' time.

Three weeks later I was sent for to see the same woman, who was then very emaciated, exceedingly weak, and suffering intense pain in the abdomen, with the knees flexed upon the pelvis, and with an exceedingly fetid, profuse, and sanguinolent discharge from the vagina.

Pressing my hand upon the abdomen, I found the bladder greatly distended with urine, and upon investigation I discovered that she had not passed any water for several days. Catheterization relieved this condition, and examination by the vagina showed the existence of another sloughing fibroid tumor. This was readily removed with the forceps and fingers. The patient recovered promptly, though she was still weak when last seen.

About three months later she came to my office exceedingly pallid, with the statement that for some time she had been suffering from most profuse uterine hemorrhages. Examination revealed, protruding from the vulva, a mass about the size of a small apple. Constant loss of blood was taking place, and the patient was so anæmic that she nearly fainted in my office, and had to be sent in a carriage to the Polyclinic Hospital. The vagina was packed, and the

[1] Read at the Philadelphia County Medical Society, December 19, 1891. For discussion, see page 82.

patient given full doses of quinine and whiskey. This was in March, 1891. After having been kept in bed for several days, she was etherized, and a full examination of the uterine condition made. I found what I had previously suspected—a small growth attached to the fundus of the uterus, which had caused inversion of that organ. The mass occupying the vaginal outlet and the vagina was, therefore, the uterus, which had been turned inside out, with the attached polypoid, fibroid tumor. I readily tore loose from the mucous membrane of the inverted uterus what was found to be two small fibroid tumors, one about the size of a black walnut and the other rather smaller. They are shown on the plate containing the specimens, but are now shrunken from long immersion in alcohol.

An effort was then made to replace the inverted uterus by continuous pressure, made with the fingers introduced into the vagina. This was continued for a long time, but proved ineffectual. I considered at the time the propriety of removing the inverted uterus by performing partial or complete vaginal hysterectomy. It seemed to me, however, that it would be wise to make a further attempt at replacement before adopting radical measures. The patient was accordingly kept in bed nearly two weeks, in order to build up her general health by stimulus and tonics, before making further attempts at invaginating the inverted uterine walls.

She was then again etherized, and a prolonged effort was made at replacement by means of the fingers and Aveling's repositor. The manipulation was kept up for an hour and a half, but was absolutely useless, although the pressure was made in a very continuous manner. The patient became so weak that I feared she might die upon the table, and I therefore abstained from further manipulation, and again put her back to bed.

Two weeks later another effort was made to overcome the inversion of the womb. I was assisted on this occasion by Drs. Baldy, Baer, and Anna M. Fullerton, whose counsel and aid I felt that I greatly needed. The abdomen was opened by a median incision, when the coils of intestine occupying the pelvis were seen united by recent lymph, evidently due to the traumatism of the previous manipulations. An endeavor was made to correct the condition of the uterus by means of strong forceps introduced through the abdomen to dilate the uterine neck, while pressure from below was made with the fingers in the vagina. Although these manipulations were performed by such skilful operators as those I have mentioned, we were unable to make any marked impression upon the displaced organ. Unfortunately, I had not provided myself with the most approved form of forceps. I then pushed through the fundus of the uterus a large needle carrying a strong piece of fishing-line, to which was attached at the vaginal end a button of soft metal. I hoped that traction on this cord through the abdominal wound would, by means of the button pressing upon the mucous membrane of the uterus in the vagina, cause the uterus to assume its proper condition. While dilatation of the inverted fundus was made by means of the forceps, traction was made upon the string and pressure upward through the vagina. The muscular contraction of the uterine neck, however, prevented anything being gained by this manipulation, although the force applied was such as to finally cause the button to pull through the fundus of the uterus and to make its exit into the pelvis. After spending considerable time in these unsuccessful attempts, I finally did a partial vaginal hysterectomy, removing the inverted portion high up and stitching the edges of the uterine wall at the fundus together. This procedure was resorted to only after the patient had been under ether for three hours, and was so overcome by shock that her condition was extreme. She did not react, her temperature not rising above 95° F., and she died within a few hours.

The abdominal wound was then opened, and a very small amount of blood found near the stump of the uterus. Evidences of non-septic traumatic peritonitis, due to the previous manipulation, were present, as has been stated in the account of the last operation.

In looking back upon this case, I cannot but feel a sense of regret that the more radical operation of vaginal hysterectomy was not done at the time that the patient was subjected to operation for removal of the tumors causing the inversion. My desire to avoid an operation accompanied by shock and hemorrhage at the time she had been so depressed by violent and repeated flooding, made me adopt what at the time seemed a less radical course. The extreme difficulty of dilating the uterine neck in cases of inversion was not appreciated by me until I found my attempts at replacement futile.

Society Notes.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, December 23, 1891.

The President, JOHN B. ROBERTS, M.D., in the Chair.

OPHTHALMIA NEONATORUM AS A CAUSE OF BLINDNESS,[1]

WAS the title of a paper by T. B. SCHNEIDEMAN, M.D.

DISCUSSION.

DR. GEORGE E. DE SCHWEINITZ: Unfortunately, I came into the room too late to hear the first portion of this paper. There is no question that bichloride of mercury, under ordinary circumstances, is an excellent germicide, but in spite of the good results which have been reported, I am very much against the use of strong solutions of this drug in ophthalmia neonatorum. It is true that investigations have shown that a solution of 1–10,000 will retard the vitality of certain bacteria—for example, staphylococcus pyogenes aurens; but in opthalmia neonatorum and in gonorrhœal ophthalmia the characteristic behavior of the gonococci is their residence within the living cells, and under these circumstances I do not believe it is possible for irrigations of bichloride of mercury to act in their ordinary germicidal functions. Moreover, I am convinced from clinical and direct histological experience that strong solutions of sublimate have a distinctly deleterious effect. I need not refer at any length to the disastrous results to the cornea that have occurred from the use of this drug in strong solutions during cataract operations. Especially is this true when they have been employed to irrigate the anterior chamber. It is of the highest importance during ophthalmia neonatorum that the epithelial surface of the cornea shall be kept intact; and while I am not prepared to say that the use of a

[1] See page 75.

strong solution can actually produce an abrasion, I am well satisfied that it adds distinctly to the dangers of the case. A recent European investigation in regard to the effect of this drug upon the cornea, has demonstrated its capacity for producing changes that might well make one hesitate in its employment in very active strength. It should be remembered that during the height of an attack of ophthalmia neonatorum the resisting power of the cornea is materially decreased, and hence very irritating solutions, no matter of what composition, are to be deprecated. I beg to be understood in this matter; I do not for one moment dispute the value of bichloride in purulent affections of the conjunctiva, but I deem it inadvisable to use the drug in strong solution, and believe that it is impossible to employ it *safety* in such strength that it will act as a *true germicide*. Moreover, it has been shown that bacteria in the presence of albumin have the power to reduce bichloride of mercury to calomel. Now calomel, to a certain extent, is a germicide, but must have very inferior qualities under these circumstances. There does not seem to be any objection, for cleansing and antiseptic purposes, to a strength of 1–10,000 (Cohn, in his recent book, recommends 1–5,000). A convenient strength is a grain to the pint—*i. e.*, about 1–7,500. In the Philadelphia Hospital, as my colleague, Dr. McKelway, will testify, we are in the habit of using alternately a solution of bichloride of mercury, a grain to the pint, and a saturated solution of boric acid. If the cleansings are made hourly, first one and then the other drug is employed. Boric acid is without germicidal value, but it is an excellent slightly astringent cleansing agent.

Referring to the other portion of the treatment advocated by the doctor in his paper, I beg to agree with him most emphatically—*i. e.*, with his use of nitrate of silver. It should not be employed in the earlier stages, or in any stage in which there is much infiltration and the formation of false membrane; but when there is free secretion of yellow pus, when the lids are supple, when the conjunctiva is covered with hypertrophied papillæ and positive granulations, nitrate of silver, in the strength of ten to fifteen grains to the ounce, is the germicide *par excellence*. Applied carefully with a cotton mop, and properly neutralized, if strong solutions are employed, any irritating effect upon the cornea may be avoided. It acts in three ways: As a germicide, because it is at the same time a superficial caustic, destroying a layer of epithelial cells and probably the bacteria which are contained within them; as an astringent, and as an alterative, using that term to imply its efficiency to alter the nutrition of a mucous membrane which is inflamed.

In regard to the other solutions which various surgeons have employed in this condition—carbolic acid, aqua chlorini, weak solutions of nitrate of silver, etc.—my experience is limited. They come to us endorsed with high authority. In regard to one drug, however, I wish to place myself on record—namely, pyoktanin. I hope that no one will treat cases of purulent ophthalmia in the newly-born with this drug.

Finally, I may say that, in my belief, that the more or less continuous application of cold is of great value in the earlier stages. The essayist has referred to atropine and aserine, evidently giving his preference to the former drug, should corneal ulceration indicate its use. I would reverse the order, and place eserine first, provided no iritic complication contra-indicates its instillation.

Dr. Charles H. Thomas: There is one suggestion growing out of what Dr. Schneideman has said which seems worthy of further amplification—that is, the question of some legal enactment which shall help to prevent the blindness which is so frequently the result of ophthalmia neonatorum. Such a law has been enacted by the State of New York, and there has been some attempt to establish one in the State of Pennsylvania. It seems to me that there is no place in the State of Pennsylvania where a movement with this object in view could be more effectively inaugurated than in this society. It is my hope that all who have heard this very able and true statement will resolve themselves into a committee to further the enactment of such a law as has been suggested. There is no question as to the propriety of compelling midwives to report such cases, and I am not sure but that we could go further with propriety, and require medical practitioners to report these as well as other cases of infectious diseases. There are, of course, many physicians who should not be put to this trouble, but there are others who see but few such cases, and it would have a wholesome moral effect upon all to feel that this disease was dignified enough to require a report to the Board of Health.

Dr. Charles P. Noble: I will speak upon this subject from the standpoint of the obstetrician rather than from that of the ophthalmologist. There are several points which interest me. I am much pleased to find that so long ago as 1807 some one had insisted upon the fact that the treatment of ophthalmia neonatorum should begin with the mother. This has been insisted upon by various obstetricians, and I have myself long felt the importance of it. It has been a rule with me for some years to pay attention to the question of vaginal discharges in pregnant women. If there is a free vaginal discharge, even though no complaint is made of its irritation, I have always made a local examination, and if vaginitis were found to be present, have insisted upon systematic local treatment. I think that this is a most important point, and one that is even more important than the early treatment of the eye. If we can prevent infection, we do not need the early treatment of the ophthalmia. Some years ago, when connected with the Lying in Charity, I saw quite a number of cases, and I have had several in private practice. I may say that among these cases there was only one in which an eye was lost. This occurred in a syphilitic infant. In this case Dr. Lautenbach acted as consultant, so that the child had everything that ophthalmological science could do for it. The treatment used at the Lying-in Charity was frequent irrigation with a saturated boric acid solution. When the discharge was very free, it was used as often as every half hour, together with silver nitrate solution (10 grains), used twice daily. It was thought that advantage was derived, particularly when the swelling was great, from the application of cold compresses.

Speaking still from the standpoint of the obstetrician, I should advise that the practitioner always avail himself of the counsel of an oculist in the management of such cases. He will thus be saved the anxiety and regret of occasionally losing an eye, and forever injuring the prospects of the infant.

On motion, the following committee was appointed to confer with the State Board of Health relative to this subject: Drs. T. B. Schneideman, O. H. Thomas, Benjamin Lee, Edward Jackson, G. E. de Schweinitz.

SOME MOOTED POINTS CONCERNING THE VOMITING OF PREGNANCY,[1]

Was the subject of a paper by T. RIDGWAY BARKER, M.D.

DISCUSSION.

DR. CHARLES P. NOBLE: Dr. Barker prefaced his remarks by saying that he should not take up the matter from a theoretical standpoint, and that he would not present the theories held by others, but would study it from the standpoint of anatomy. I think, however, that the theory he advances, that the vomiting of pregnancy is reflex in its origin, due to growth of the ovum, is a very old one. There are a great many theories to account for this affection. Among the most important is that held by Grailly Hewitt—namely, that the vomiting is due to induration or inflammation of the cervix or to flexion. Dr. Hewitt has gone very fully into this subject, and while we may not agree that this is the only cause of vomiting of pregnancy, yet any one who has studied the large number of cases which he reports, cannot help but feel that there is a close relationship between exaggerated flexion of the uterus and also induration of the cervix due to inflammatory trouble and the vomiting of pregnancy. I have myself not infrequently seen this combination. I have also seen vomiting associated with more or less endometritis, and with induration and thickening of the cervix which was present before pregnancy took place. Again, the uterus may be more or less fixed by old inflammatory trouble, and when it becomes pregnant it is prevented from rising into the belly, as is usually the case, and in that way also reflexes are increased. Again, we know that the uterus may be retroverted and caught under the promontory of the sarcum, and then may be prevented from rising into the abdomen, and may produce such reflex symptoms. I am satisfied that old inflammatory trouble in the pelvis has a great deal to do with the vomiting of pregnancy. It, however, simply acts to increase the reflexes from the uterus.

A more recent theory, and one supported by so eminent an authority as Kaltenbach, is that the vomiting of pregnancy is hysterical. I think that there is no doubt that a certain number of cases are due to hysteria. But I would not go so far as to hold that all cases are due to this cause.

There is no question that not only do we have as a result of pregnancy changes in the pelvis, but the whole body of the woman increases in size and undergoes changes. The entire vascular system becomes hypertrophied, and the heart also becomes enlarged. We know that pregnancy changes the entire form of the woman. The entire system is involved, and we can readily understand that congestion of the alimentary canal can be brought about. We all know that the nervous system in the pregnant woman is extremely irritable. It resembles the nervous system of children. For this reason, irritation from the pelvis which ordinarily would not be sufficient to cause reflex symptoms, can do so at this period.

The doctor assumes that the reason why primiparous women are more apt to have vomiting than multiparæ, is because the uterus of the multiparous woman is larger, and therefore the growth of the ovum would not cause so much distension. There is no question concerning the fact, but the explanation is not so satisfactory.

It is true that the uterus of the multipara is larger than that of the primipara. It is also true that the abdominal walls are more relaxed, giving a less degree of intra-abdominal and intra-pelvic pressure. The woman is better prepared for a pregnancy, having already been pregnant. The mental condition is probably not so disturbed, and the emotions not so excited in the multipara. All these points must be considered. Moreover, it must not be forgotten that the uterus grows as well as the ovum, so that it is at least questionable whether the ovum distends the uterus. Does it not simply fill it?

It seems to me that the practical outcome of the whole matter is that, given a serious case of vomiting in pregnancy, it is the business of the practitioner to find the cause of the trouble. Whether it is extrinsic purely—due to indigestion or to uræmia; or whether due to excitability of nervous system or to hysteria; or whether some pelvic lesion is the source of irritation. If this plan of treatment were followed, better results would be obtained.

CASE OF INVERSION OF A NON-PUERPERAL UTERUS,[1]

was the title of a paper by JOHN B. ROBERTS, M.D.

DISCUSSION.

DR. CHARLES P. NOBLE: It has been my experience to see two cases of inversion of the uterus, and in both cases the attempts at reduction failed. The first case I saw at the Lying-in Charity, and was, I think, a long-standing post-puerperal case. Manual reduction was tried, but abandoned for the reason that the uterus was soft and macerated. In this case the uterus was amputated and recovery occurred. The second case I saw with Dr. Kelly, and was present at an operation in which he opened the abdomen. The abdominal neck of the inversion was dilated with forceps, and manipulations were made with one hand in the belly and one in the vagina, but the effort at reduction failed. In that case Dr. Kelly took out the whole uterus, and the patient made a good recovery.

Speaking of the treatment, Dr. Roberts did not mention one method which has met with excellent results. It is the method of gradual reduction advised by Dr. Aveling. Constant pressure on the inverted uterus is made through a repositor, which is attached by elastic bands to a support about the waist. A large series of cases has been reported in which this method has been employed with almost universally successful results. Of course, in some cases the presence of adhesions will prevent the reposition of the uterus. The reasons for the success of this plan is plain. The problem is to overcome the resistance of the muscular tissue in the upper part of the cervix, and to make it relax and dilate. This tissue is resistant enough to tire out the muscles of the surgeon when attempting rapid reduction, but gives way before the steady action of the rubber tapes. It seems to me that in a case of any standing attempts at rapid reduction are inadvisable, and are liable not only to fail, but to do harm. It seems to me that in a long-standing case of inversion the thing to do would be to pack the vagina with an astringent tampon, and afterward apply the gradual method of Aveling. If that did not affect reduction, the best thing would be to do a radical operation. The question arises whether it would not be better to remove the ovaries and tubes, which would bring about a cessation of the hemorrhage. This would be a simple matter, and I think

[1] See page 78.

[1] See page 79.

that reduction in the size of the uterus would take place. If this were not done, I think that a simple amputation of the protruding mass would be quite a feasible operation, but, of course, the danger there would be that after the mass of the uterus was removed the remainder would reinvert itself, and possibly infect the peritoneal cavity. This could be obviated by using transfixion pins. My own feeling would be in favor of removal of the tubes and ovaries, and later to do a vaginal hysterectomy if necessary.

DR. ROBERTS: In this case the uterus was not soft, but was as hard as a fibroid tumor. The tightness with which the neck grasped the inverted uterus was something astonishing.

I am somewhat familiar with two other cases of inversion of the uterus. One happened some years ago in the country. The practitioner did not know what was protruding after labor, and sent for Dr. Levis, who, after a good deal of manipulation, pushed the inverted uterus back. The second was also, I think, a puerperal case, and happened not long ago at the Woman's Hospital of Philadelphia; in this instance the physician was able, after manipulation for several hours, to replace the uterus. It was, perhaps, the knowledge of these cases which led me to make such prolonged attempts at reduction. I see now that it was unwise, and I agree with Dr. Noble that if such a case again came under my care, I should be inclined to first remove the ovaries, and if that were not sufficient, to make a total hysterectomy. This patient was *in extremis* at the time, and I did not feel justified in doing a too radical operation when I removed the two small tumors.

NEW YORK ACADEMY OF MEDICINE.

SECTION ON ORTHOPÆDIC SURGERY.

Stated Meeting, December 18, 1891.

SAMUEL KETCH, M.D., Chairman.

CONGENITAL ABSENCE OF A PORTION OF BOTH LOWER EXTREMITIES.

DR. JOHN RIDLON presented a boy, ten years old, who had been brought by Dr. Manning to the last meeting of the Hospital Graduates Club. There was an entire absence of all the parts below the condyles of the femur, and just posterior to the extremity of each of these stumps was a fleshy mass which probably represented the undeveloped digits. The boy could walk quite well on these stumps, and at present was wearing artificial limbs, but as these caused pain, he had presented the boy with the hope that some suggestions might be offered as to the best way of treating the case. It was questionable whether an artificial leg with a joint at the knee could be applied to limbs of this length, and hence, the question of amputation might properly be considered. Personally, he was in favor of applying artificial legs without any knee joint, directly to the stumps without operative procedures.

DR. W. R. TOWNSEND thought that the fleshy masses would interfere with the proper application of these artificial limbs, and hence favored removing them.

DR. J. E. KELLY thought the fleshy masses were undoubtedly the remains of the undeveloped lower portions of the limb. He thought their position the normal one in utero. He had seen, within the last few months, a somewhat similar amputation in the upper extremity, with rudimentary digits which were capable of movement.

DR. T. HALSTED MYERS, on examination, found a slightly movable bony mass between the condyles of the left femur, probably a poorly developed patella. He thought the case one of non-development, not amputation.

DR. MYERS presented a case of

CONGENITAL DEFORMITIES OF THE UPPER AND LOWER EXTREMITIES,

and asked the opinion of the Section as to the value of operative procedures for the relief of the constrictions caused by amniotic bands.

DR. KELLY thought the phalanges of the great toes were perfect in this case, but that the digits had been suppressed, and development had taken place beneath the skin.

The chairman referred to a child he had seen in which there had evidently been an attempt at amputation in utero. There was a deep constriction just above each ankle, more marked, however, on one side. The mother of this child, quite early in pregnancy, was tripped by a cord which some boys had tied across the street, and it was thought that this maternal impression was responsible for the deformity. The child was able to walk with the aid of ordinary ankle supports.

DR. TOWNSEND did not favor operating upon these constricting bands, for the resulting cicatrix would cause further contraction.

POSTPONED DISCUSSION ON DR. J. E. KELLY'S PAPER ON "THE ANATOMY OF THE FOOT, WITH EXHIBITION OF A NEW CLUB SHOE."

DR. ROYAL WHITMAN said that the author had spoken of removing a wedge-shaped piece from the cuneiform bones, but as these bones were quite small, their dimensions varying from one-half to one inch, it was evident that a cuneiform osteotomy on such bones would be impracticable. The calcaneus could, of course, be treated in this manner by cutting to a considerable depth, but such an operation was totally unnecessary. When one recalls the fact that the astragalus is poised on the oscalcis in unstable equilibrium, there seems to be no reason for increasing this instability. Such operations might be allowable if it were true, as has been stated before in the Section, that the radical cure of flat-foot was impossible, and that all that could be hoped for was relief. He had seen more than three hundred cases of flat-foot, and he believed that a radical cure without operation was not only possible, but easy.

DR. A. B. JUDSON said that the mechanical toy constructed by Dr. Kelly, admirably illustrates the fact that human locomotion resembles the action of a wheel in motion, in which the legs are the spokes and the feet are the felloes, as pointed out by Dr. Holmes. That ordinary locomotion is a continual falling, and a continual recovery is seen in the gait of a child learning to walk, and in the titubation of a drunken man whose body inclines in a given direction, and would fall if the legs and feet failed to make a timely movement forward to prevent a fall.

Dr. Judson said that Dr. Kelly's apparatus takes advantage of the weight of the body for the correction of the varus. It is well known that varus corrected to a certain point, and held there, is further corrected by the weight of the body applied in successive blows, as the child runs about. On the other hand, if the varus is reduced only to a point on the wrong side of the line between deformity and symmetry, each foot-fall is a blow increasing the varus. Dr. Cook, of Hartford, had shown a varus shoe at

Washington last summer, which had attached to the sole a flat piece of steel extending outward a few inches, to enable the weight of the body to act in a favorable manner on the deformity. He had seen a horse treated for some affection which made it desirable to prevent extension of the foot, by the application of a horse-shoe having a long posterior prolongation. The veterinary surgeon can attach his apparatus with absolute firmness to the foot, but in our patients the foot is liable to turn over inside of the shoe. As a rule, the weight of the body can be made more effective by the use of an apparatus having an upright extending up the leg, and a steel foot piece in which the foot is prevented from rolling by a strip of adhesive plaster.

DR. R. H. SAYRE said this succession of falls during the act of locomotion, was well-shown in instantaneous photographs of athletes running. The shoe exhibited by the author was doubtless intended for the treatment of club-foot in the later stages, when it was possible for the foot to be placed flat on the ground in a fairly good position. Before this stage, the shoe could not be easily adapted to the crooked foot. The usefulness of this "snow-shoe" was not so much on account of its shape, as to the fact that there was a long lever on the outer portion of the foot which prevented the child from standing on this outer portion.

In connection with this shoe, he had intended to exhibit a shoe which one of his patients devised for his own use. His shoe was made with the sole sloping outward for some distance, thus answering the same purpose as the snow-shoe. This patient had adhesions and contracted tendons following infantile paralysis, so that the weight of the body was unable to do more than prevent an increase of the deformity. The foot was only brought straight by subcutaneous tenotomy and the use of very strong force applied by means of Bradford's instrument.

The Chairman said that many instances were recorded in which this principle of utilizing the weight of the body had been embodied in various kinds of apparatus. In some cases of equinus, the patients have been allowed to walk without apparatus with the idea of utilizing this factor.

"A CONSIDERATION OF SOME OF THE AFFECTIONS OF TENDON SHEATHS AND BURSÆ, AND THEIR RELATIONS TO INJURIES AND DISEASES OF THE JOINTS."

DR. ROYAL WHITMAN read a paper with the above title. He briefly described the structure and anatomical relations of bursæ and tendon sheaths, their diseases and appropriate treatment, calling attention to the fact that chronic disease of tendon sheaths was usually tuberculous in character, for which early removal was the only remedy.

The relation of the tendon sheaths to the ankles and wrist-joints, and their liability to injury in sprains and fractures, explained the symptoms—weakness, local pain, and limitation of normal motion, often persisting after such injury.

The importance of local massage and stimulation in the early stage, in order to prevent the formation of adhesions after secondary inflammation of tendon sheaths, was urged.

In chronic and neglected sprains, a careful examination should be made, and if adhesions or contractions were present, treatment should be directed to a recovery of the normal range of motion. This result might often be accomplished by a forcible overstretching under ether, followed by massage and support. By such treatment, patients disabled for many months, might be quickly and permanently relieved.

In conclusion, attention was called to the importance of slight injuries in childhood, which might be the starting point of tuberculous disease, the diagnostic value of chronicity, and the necessity of careful observation and early treatment in suspicious cases.

DR. JUDSON said that he had seen a case of tumor of the semi-membraneous similar to the one shown in the model. The child was about six years old, and under a purely expectant treatment, the tumor disappeared in the course of a few months, leaving no deformity or disability.

DR. TOWNSEND said that he had seen many of the cases referred to by the author, and he had been struck with the many and varied diagnoses which had been made upon them before they came to the dispensary. The diagnosis in the early stages is often difficult, especially when there is only a meagre and often misleading history such as accompanies most dispensary cases. The importance of differential diagnosis could not be too strongly emphasized, particularly as upon it depended a correct prognosis.

DR. C. A. POWERS said that he inferred from the author's remarks on injuries at the lower end of the radius, that he recommended confining the flexor and extensor tendons of the fingers in the treatment of Colles' fracture. He saw a large number of these cases with functional disability following this method of treatment, and he therefore preferred to use the long anterior splint for the first five or six days, and then to shorten both the anterior and posterior splint to the first row of the carpus, directing the patient to make very active use of the fingers. Four or five days after this, he expected them to be able to shut the fingers well down into the palm.

DR. KELLY said that in Dublin, the home and birthplace of Colles' fracture, the keel-shaped splint which avoided injurious pressure on the thenar and hypothenar eminences, was almost universally employed. The mode of the development of bursæ on various points exposed to pressure is difficult to understand, unless we remember that the peritoneum which is the great areolar inter-space of the body, has had a similar development from the connective tissue structures.

He was glad that the author agreed with him as to the position of the foot, viz.: slight adduction with the foot at right-angles to the leg. This slight adduction produces what he called "artificial talipes varus."

The Chairman said that he inferred from what the author said, that he considered these bursal tumors of tubercular origin. He wished to dissent from this opinion, for many of them were benign, and the result of injury.

DR. WHITMAN explained that he had spoken of slow, chronic enlargement of the sheaths of the tendons of the wrist and hand as tubercular. The deep seated bursæ were favorably located for tubercular inflammation, and accordingly when they underwent chronic enlargement, he preferred to treat them radically. He had only incidentally referred to the treatment of Colles' fracture. He did not consider the confinement of the fingers with vigorous massage and local stimulation the same as the confinement treatment which had been criticized during the discussion.

EXHIBITION OF AN IMPROVED ADJUSTABLE SCHOOL DESK AND CHAIR.

MR. E. E. HICKS exhibited a chair and desk which he had devised, and to which reference was made in

the recent discussion on the subject of the relation of faulty attitudes to lateral curvature of the spine.

The desk and seat admit of an independent vertical adjustment of four inches, which is manipulated by means of a key. The slope of the desk can also be varied to suit individual requirements. The desks and seats can be folded so as to occupy very little space, thus facilitating cleaning the school-room and allowing room for gymnastics. The seat and desk have a common base of support; a child using the desk, therefore, occupies the seat joined to the desk next behind. This improved desk costs only about fifty cents more than those now found in the market.

DR. R. H. SAYRE thought this desk was a decided improvement on the usual style.

The Chairman thought it might be desirable for a child already suffering from lateral curvature; but he did not believe that faulty attitudes at school were the cause of rotary lateral curvature.

TUBERCULAR DISEASE OF THE VERTEBRÆ IN ITS EARLY STAGES.

DR. R. H. SAYRE presented the second, third, and fourth lumbar vertebræ of a patient, showing a very early stage of tubercular disease. There was a cheesy mass in the third lumbar vertebra which had not yet broken down and ulcerated through into the cartilage. The points of junction between the second and third, and the third and fourth vertebræ were apparently normal. There was an extravasation of blood into the vertebra. The history of the patient from whom these specimens were taken was quite interesting. A child suffering for some time from chills and high temperature, began to have a peculiar posture and mode of locomotion, and to suffer from abdominal pains. This led to a diagnosis of spinal disease; but in a consultation with an orthopœdic surgeon, this opinion was not confirmed; the latter believing that the child was suffering from malaria. The symptoms not subsiding under the administration of quinine, the child was brought to Dr. L. A. Sayre, who concurred in the diagnosis of disease of the spine. At this time there was some psoas contraction of the right side, with spinal rigidity and very slight pains. It could hardly be said that there was a kyphosis; the lumbar spine was straight instead of concave. The child was placed in a wire curiass. About a month later he suddenly developed a temperature of 104°, with vomiting, photophobia, phonophobia, stiffness of the neck, and a rapid pulse. He was then seen by the speaker, who found an abdominal enlargement near the left side of the umbilicus, which could be separated by percussion from the spleen. It was quite freely movable. Small doses of bichloride of mercury were administered, and in a few days the temperature fell to 100°, and remained at this point, and the other meningeal symptoms disappeared. There was no colic indicating tubercular peritonitis. The child became now even more anæmic than before, and the abdominal swelling increased in size. It seemed hardly possible that the mass could be a psoas abscess pointing in such an uuusual position. After some time the mass became larger, and moved towards the posterior surface of the abdomen. In consultation with Dr. W. T. Bull, it was decided to be inadvisable to operate. The child died six days ago, and for a few days before death there was slight jaundice. The post-mortem examination showed that the abdominal tumor was formed by a tubercular mass which united the intestines into one large mass. There was no small miliary tubercles scatterred over the peritoneum. One little band pressed upon the gall bladder, and so accounted for the jaundice. The kidneys were firmly bound down with adhesions, and the left one was very large and waxy, and its pelvis was much dilated. There was a large quantity of fluid in both pleural cavities, and cheesy nodules at the apices of the lungs. The heart was enormously thickened; the brain was not examined.

The Chairman thought the symptoms described were more like those of an acute non-tubercular meningitis, as in the initial stage of the tubercular variety, a high temperature was unusual, and the pulse was ordinarily slow or intermittent. Then, again, the subsidence of the symptoms was not in accordance with such a diagnosis.

DR. KELLY called attention to the fact that in the early and late stages of tubercular meningitis the pulse was rapid, while in the intermediate stage it was slow.

DR. RIDLON said that he inferred from the remark of the Chairman that he shared in the general feeling in the profession, that if a child survived it was proof that the meningitis was not tubercular, and *vice versa*. He desired to dissent from this opinion. Eight or nine years ago he had treated a boy who had suffered from a form of meningitis which several eminent consultants considered to be tubercular; and they had an opportunity of seeing the patient a good many times. The patient was still alive; but he did not believe this proved that the diagnosis was incorrect.

The Chairman said that he had never seen one undoubted case of tubercular meningitis recover, although he believed there were a few such cases on record.

DR. H. W. BERG was not aware that there was any symptom, either subjective or objective, which would enable one to make a diagnosis between simple and tubercular meningitis. He thought that where there was a high temperature at the beginning of a meningitis, it was due to a series of eclamptic seizures, which, by paralyzing the heat center of the body, allowed of a sudden rise of temperature.

DR. TOWNSEND had had an opportunity of seeing a considerable number of cases of tubercular meningitis, almost all of which had been proved by autopsy to be tubercular, and he could not recall any case where there was an extremely high temperature at the beginning.

DR. R. H. SAYRE said that he had looked upon the meningitis as tubercular, because of the very general tubercular infection. The child looked as if it would die within a few days after the onset of these meningeal symptoms, and he was much surprised when the acute symptoms subsided so rapidly. The high temperature might have been due to the abdominal lesions. The extent of the abdominal lesions was remarkable, as they were younger than the disease in the spine.

DR. T. HALSTED MYERS,
Secretary.

24 WEST FIFTIETH STREET, NEW YORK.

PROF. KAUFMAN, of the Veterinary College at Alfort, has discovered that chromic acid, used hypodermically, will destroy the poison of snakes and other venomous reptiles.

The treatment consists in the cautious employment of a 1 per cent. solution by the ordinary hypodermic syringe; and, at the same time, where the bite happens to be at one of the extremities, the limb should be ligatured, in order that the medicament may have an opportunity of being diffused throughout the tissues.

THE CLINICAL SOCIETY OF MARYLAND.

Two Hundred and Fifty-ninth Regular Meeting at Baltimore, December 18, 1891.

THE Society was called to order by the President, DR. ROBERT JOHNSON.

DR. C. W. MITCHELL read a paper, entitled

AFTER INFLAMMATION—WHAT?

DR. WM. B. CANFIELD read a paper on

DUST AS A CAUSATION FACTOR IN PULMONARY DISEASE.

The various kinds of dust may be divided into animal, mineral and vegetable. Opinions differ as to which kinds are most dangerous when inhaled. That which is generated in brush factories is animal and very harmful. Makers of hats, especially felt hats, suffer much from the dust evolved. The vegetable dust that does the greatest and most lasting injury to the lungs is that generated in tobacco factories. This dust has not only a mechanical action, but has also poisonous effects.

It is in connection with the inhalation of mineral dust that the greatest amount of scientific investigation has been made, especially in relation to the diseases called the consumption of grinders, miners, potters, etc. Anthracosis, silicosis, siderosis, chalicosis, tabacosis, and other kindred names have been suggested to describe a similar condition produced by various kinds of dust. Zenker has handed down the word "pneumonokoniosis" to cover all these conditions. The history of these cases is very much alike. They begin with simple bronchitis, which gradually becomes chronic. They are usually non-tuberculous, at least at the beginning tuberculous complication is only an accident.

Where one is exposed to an atmosphere of dust the contact of this dust with the sensitive nasal and laryngeal mucous membrane sets up coughing and sneezing, and much of the dust is expelled, and, for a time, no harm results; but a continued exposure to this dust causes a congestion of the mucous membrane of the nose and breathing passages, and, in time, an inflammation of the whole tract; the ciliated epithelium loses its power, and dust finds its way to the ultimate ends of the lung tubules. When the individual is asleep, or absent from this irritation, the ciliated epithelium gets rid of a large part of this foreign substance, and the wandering cells may close around some of this dust and try to carry it off, or render it harmless by burying it in a lymphatic gland. Much, however, finds its way either through the epithelium, or between the cells into the submucous layer, getting into contact with the connective tissue of the alveoli, and by irritation causing a hypertrophy of this tissue, and a condition resembling chronic interstitial pneumonia or fibroid phthisis. The general opinion seems to be that the fibroid condition seems to oppose a direct barrier to the growth and multiplication of the bacillus tuberculosis, and in large tracts of lung tissue converted into this material often not a bacillus could be detected. In one of the author's cases, bacillis were found in abundance, and yet two years after the man reported himself as entirely well.

The color of the expectoration is a prominent sign in these cases. In one case of the author, a stoker, the expectoration still continues absolutely black at times, and always tinged, although it is almost two years since he gave up his occupation. Examination of this sputum under the microscope showed it to contain in abundance carrier cells, which in all cases contained pigment, and in some instances the black crystalline coal could be recognized within these cells. This pigment and foreign material has a tendency to collect at the apices of the lungs, and is only present at the bases when the dust inhaled is excessive in amount and exposure prolonged.

In diagnosis, physical signs do not yield as much as the microscope. By the microscope we see the cells containing the dust. In the author's cases (4) râles were heard on auscultation, but nothing marked was obtained on percussion.

The prognosis is good if the man has not worked too long at the occupation.

The treatment is to take the patient from his dangerous occupation, when improvement begins at once. Owners of large factories are adopting stringent prophylactic measures in order that they may not lose so many good workmen. The best methods are (1) to prevent the formation or escape of dust by using wet grinding or by grinding in closed vessels. This is not always practicable. (2) To prevent inhalation of dust by wearing respirators, etc. But these are uncomfortable and the men remove them at every opportunity. (3) The removal of dust as fast as it is produced, by using fans and air shafts. This is by far the best plan.

Still further, the following rules should be enforced: (1) Workmen should change their outer clothing after work. (2) They should keep their faces and hands as clean as their work will allow. (3) They should never be allowed to eat in the work-room.

DR. RANDOLPH WINSLOW related

A CASE OF ELEPHANTIASIS SCROTI.

J. C., colored, aged forty-four years, was admitted to the University Hospital, September 7, 1891, on account of enlargement of the scrotum and perineum. His father died of meningitis and his mother of phthisis. Patient is one of seven children, six of whom died of phthisis. He had measles in childhood, typhoid fever at twenty, and gonorrhœa about eight years ago. The present disease begun about three years ago, with slight thickening of the tissues of the scrotum, penis and perienum, the infiltration first showing itself in the skin of the scrotum and increasing slowly, until at the time of his admission, the scrotum was enormously enlarged and reached one-third of the distance to the knee. There were a number of suppurating sinuses and superficial abscesses in the scrotum and perineum. There was some pain. The tissues of the scrotum were brawny, and very little impression could be made on them by pressure. The perineum was composed of similar tissue and was enormously hypertrophied. The skin of the penis was also thickened, but retained its suppleness and the prepuce could easily be retracted. The patient said that his virile powers were unimpaired. He was a sailor, but had never been much beyond the coast of this country, and had never resided in a tropical country.

Several efforts to detect the filaria sanguinis hominis were unsuccessful.

The sinuses were incised and a long incision was made in the perineum to relieve tension and allow the lymph and blood-vessels to empty themselves. He was placed upon iodide of potassium, as syphilis could not be excluded. He did not improve, and excision of the scrotum and perineal hypertrophy was performed October 1. The skin and subcutaneous tissues were very dense and thick, and freely supplied

with blood vessels. The testicles were carefully dissected out and were uninjured. The gap in the perineum was closed with sutures, but there was not sufficient tissue to cover the testicles, hence lateral incisions were made in the contiguous skin, and strips of skin dissected up and brought over so as to form a new scrotum. The tension was great and the stitches cut out, allowing the flaps to separate considerably. Healing was effected after five dressings, and he was discharged well on November 8, relieved of pain and discomfort and ready to again resume his ordinary avocations.

W. T. WATSON, M.D.,
Secretary.

1603 N. BROADWAY, BALTIMORE.

MEDICAL AND SURGICAL SOCIETY OF BALTIMORE.

Stated meeting held Thursday, November 12, 1891.

THE seven hundred and thirty-first regular meeting of the Society was called to order by the President, DR. DAVID STREETT.

Minutes of previous meeting read and approved. Dr. A. B. Arnold was unanimously elected to membership.

TWIN PREGNANCY WITH PLACENTA PRÆVIA CENTRALIS,

Was the subject of a paper read by DR. WILMER BRINTON.

DISCUSSION.

DR. THOMAS A. ASHBY: Dr. Brinton is to be congratulated on delivering these twins alive and to have saved the mother, thus caring for the lives of three individuals at the same time. I have been fortunate in having had only a few cases of placenta prævia, in all of which the mothers were saved, but the children have all perished. A woman whom I had attended once before aborted. In this case the placenta was attached over the cervix. She has had two children born in a normal way since, and another placenta prævia with an abortion at four months. Laceration of the cervix is the cause of more intra-pelvic disease than any other one cause I know of. In my abdominal work I find there is a direct connection with lacerations of the cervix. One lady, seven years ago, aborted at seven months, when she had a laceration of the cervix; she had a tender ovary and had catarrh of the uterus, for which she came under my care. She was delivered about ten weeks ago; it was a hurried labor. I found a large laceration arrested involution, and she was on the point of septic inflammation. She made a good recovery, and I turned her over to her family physician. In these cases of cervical laceration we should not trust our patients to a nurse; we should wash out the uterus ourselves. In washing out the uterus I find it a good plan to pass the solution in on cotton wool on an applicator, and swabbing it around; this brings out the fragments better than the douche. I believe that 75 to 80 per cent. of pelvic inflammations in multipara are due to neglected lacerations of the cervix, allowing of septic absorption. Put in a bivalve speculum, and wash out with an antiseptic solution. The gynæcologist will stop work if the general practitioner will use these measures.

DR. W. S. GARDNER: I congratulate Dr. Brinton on delivering both infants alive. In regard to phlegmasia alba dolens, I think it is a septic process; it, in all probability, is not a phlebitis, but most likely it is an inflammation of the connective tissue around the vessels, and the clot in the vessels is a secondary process. A number of post-mortems in these cases have shown no clot in the vessels. Now, as to cleaning out of a uterus, there are several methods of doing this. First, there is the douche, that will remove the ordinary loose clots; then there is the swab, that will remove some things that the douche will not, but not much. The most efficacious method of removing bits of placenta is by the use of the curette, and should be more generally practised than it is.

DR. WM. H. NORRIS: There is one point that forces itself on my attention, and that is that young physicians are too prone to trust the nurse, presuming that their directions will be carried out. None but medical men or trained nurses can do these things right. A case occurred in my neighborhood, where the physician gave the nurse instructions to wash out the uterus twice daily. She washed out the vagina and in a short time a consultant was called in to see the case, when it came to light that the uterus had not been washed out. The physician did it himself after that; and this shows that the only safe plan in these cases is to do the work yourself.

DR. BRINTON: I agree with Dr. Norris that it is not safe to trust too much to the nurse in these cases, but the average doctor couldn't wash out the uterus properly; it requires some training to do this, and, unfortunately, all doctors have not had the advantages of this training. For the same reason, I do not agree with Dr. Gardner in the use of the curette; curetting a uterus is attended with some danger and I think it should be done guardedly. The point I wish to bring out in my paper and which seems not to have been touched on in the discussion, is *prompt* treatment in these cases. I prefer podalic version, but forceps can be used in some of them, when we may do as well; but in the vast majority of cases it is better to turn and deliver. Three months ago, in a case of a mulatto at term, with Dr. Robinson, we did a podalic version and did it *promptly*. Both mother and child were saved, and the child is living to-day; this is the only case I know of where the child has survived so long. The point I wish to emphasize is that these cases should be treated *promptly*.

CEPHALIC VERSION.

Was the title of a paper read by DR. W. S. GARDNER.

DISCUSSION.

DR. F. C. BRESSLER: I remember a case in which I should have done a cephalic version, but in my haste I did podalic version. She was a primipara, bleeding from a placenta prævia. I found I could cause considerable mobility of the uterus by placing my hand on the abdomen. I ruptured the membranes and introduced my hand for a leg and did podalic version. The child was lost, whereas, had I done cephalic version as I could have done, in all probability the child would have been saved. In another case I attempted to do cephalic version and failed. It was a midwife case, a multipara at eight months. She had a large vagina, so that I could introduce the whole hand. I put her in the knee-chest position, but with all my manipulation I could not get the head in position, so had to do podalic version. In this case the child was saved. Many doctors do not seem to know there is such a thing as cephalic version. If it were more generally practised there is no donbt that many would be saved that otherwise perish.

Dr. F. C. Bressler reported

A CASE OF PROBABLE FRACTURE OF THE SIXTH OR SEVENTH CERVICAL VERTEBRA.

Dr. Wilmer Brinton reported the

COMPLETE RECOVERY OF THE CASE OF PURPURA HÆMORRHAGICA RHEUMATICA

that he exhibited to the Society on the 23 of April, 1891. After nine months of treatment he has returned to his work as clerk. The treatment at first, as I stated when I exhibited him here, was the administration of gallic acid, tannic acid, etc., all of which seemed to do him no good. Then I put him on large doses of salicylic acid, large doses of elixir of iron, quinine and strychnine; and, I am glad to say, for the encouragement of some of you, who may look upon some of your cases as hopeless, as I did on this one, that after prolonged and persistent treatment he has returned to his work.

J. Wm. Funck,
Rec. Sec'y.

1710 W. Fayette St., Baltimore.

The Polyclinic.

COOPER HOSPITAL.

CHRONIC CORPOREAL ENDOMETRITIS.

When the body of the uterus becomes involved in a chronic inflammation the condition is best determined by the character of the menstrual period, the nature of the uterine discharge, and the use of the uterine sound. Menstruation will become profuse and prolonged; the uterine discharge profuse and watery; while the sound will show an increased depth of the uterine cavity, and, upon its withdrawal, will be tinged with blood. If the inflammation has extended to the muscular structure of the uterus, the sound will cause positive pain if pushed against the fundus of the uterus.—*Godfrey.*

In the *Indian Medical Gazette* for December, 1891, Banerjee records the case of a boy, eleven years old, bitten by a snake. The toxic symptoms were not checked by permanganate, but finally subsided when half a grain of strychnine had been injected under the skin, in divided doses, the injections being given every half hour till slight muscular twitching began.

Strychnine in Spinal Paralysis.—Some time ago, when speaking to you of the treatment of diseases of the spinal cord, of paralysis particularly, I requested you not to forget that recent cases of paralysis of inflammatory origin must never be treated with strychnine. I will now say a word regarding indications for strychnine in old cases, in which the original hyperæmia and congestion have made way for anæmia and atrophy of the cord. In such cases strychnine is indicated. It is certainly not a panacea, for substantial tissue changes are often not amenable to treatment. But negative results are frequently due not so much to the strychnine as to the method of its administration. In a large number of cases where the drug is administered internally, you will have to wait some time for effects, and in many, when so administered, it will produce no effect whatever, therefore I advise you to use it subcutaneously. I could mention a number of cases where it has been administered for months or longer without apparent effect, yet when given subcutaneously in very moderate doses, two or three times a week, or daily, the effect was marked.

You should remember that two men may claim to do the same thing, and yet do not the same thing at all. You will often be told by persons that they have done the same thing which you may be advising, yet on inquiry, you will find that a very different thing has been done. You will be told by these persons that they have given strychnine unsuccessfully. On inquiry you will find the dose insufficient or given improperly.

We have here the case of a child with a transverse myelitis which had been treated outside a number of months, without apparent benefit. We gave it three injections a week of one-sixteenth of a grain of strychnine. The result has been very favorable within a week or two. Before, there was no motion whatever in the legs. Now, the child is able to swing them, which is an indication of marked improvement. Certainly such a result would not have been expected from internal administration of the drug. —Jacobi, in *Arch. Ped.*

Chyluria Treated with Gallic Acid and Thymol.—G. S., aged twenty-two, admitted for chyluria, September 29, 1891, states that a month ago he first noticed that his urine was milky, but that it got clearer while he was suffering from an attack of dysentery from which he has just recovered. He is a pale, delicate-looking man, but otherwise the chyluria does not give him any discomfort. His urine is thick and quite white. On August 30, the urine was examined under the microscope, and filaria sanguinis hominis was found in the first specimen taken. To have acid gallic gr. xv thrice daily. September 1, urine still the same, but that passed during the day seems a little clearer than that passed during the night. Continue gallic acid; pil. thymol, gr. ii, thrice daily. On September 4, the dose of thymol was increased to gr. iv, and on the 7, the dose was again increased to gr. v, three times daily. The dose of gallic acid was also increased to gr. xx, three times daily. On September 9, the urine was distinctly darker in color and somewhat clearer. The improvement from this date was steady, and on September 13 the urine was quite clear. The whole of the urine passed during the subsequent twenty-four hours was saved, and found to be apparently free from chyle and of a good color. The urine, after standing, was again examined, but no filariæ were found.

There is nothing original in the treatment of chyluria with gallic acid, but as it had failed in a previous case treated by me, I decided to supplement it on this occasion with thymol, which is a very active drug and a remarkably good anthelmintic. I am inclined to think that the recovery was, at least in part, due to this drug, as the changes in the urine began to be noticed as the larger doses, gr. xv daily, were given. I have found thymol extremely useful in several cases of tapeworm, and others have reported that it will destroy the anchylostomum duodenale. In one case, however, I removed thirteen of these worms from the duodenum of a prisoner in the Presidency Jail, and the worms were alive and active, although the man had been taking thymol for weeks. As there is no known remedy for chyluria at present, it might be well to give thymol a fair trial.—*Indian Med. Gazette.*

The Times and Register

A Weekly Journal of Medicine and Surgery.

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THE TIMES AND REGISTER,
FORMED BY UNITING THE
PHILADELPHIA MEDICAL TIMES,
THE MEDICAL REGISTER,
THE POLYCLINIC,
THE AMERICAN MEDICAL DIGEST,
PUBLISHED UNDER THE AUSPICES OF THE
AMERICAN MEDICAL PRESS ASSOCIATION.

Published by the MEDICAL PRESS Co., Limited.

Address all communications in regard to Editorial and Subscription Business, to 1725 Arch Street, Philadelphia.

Address all communications in regard to Advertising, to 218 E. 34th Street, New York.

New York and Philadelphia, January 23, 1892.

INFLUENZA.

IN our "Influenza Number," last week we hoped to present our readers with a report upon the present epidemic from every State in the Union; and in pursuance of this desire we had written to many prominent physicians requesting such reports. But the replies showed that more than half our correspondents were themselves prostrated by the malady; while of the remainder many were so busy in attending the sick that they were unable to respond to our request. However, in the seventeen original reports and nineteen selected articles in the "Influenza Number" will be found many valuable suggestions as to the treatment of this malady.

When the epidemic has died out, and our friends have a little leisure, we would like to have reports from as many of our readers as will take the trouble to prepare them, on the symptomatology, therapeutics and sequelæ of the influenza as it appeared to them. From these may be prepared a history of the epidemic that would be of considerable value.

* * * * * *

The occurrence of suppuration in the middle ear, as a complication of influenza, was noted in one of the papers published last week. Several cases have since occurred in the writer's practice, in which the patients complained of ear-ache; but prolonged douches of hot water gave permanent relief.

In a number of cases erythema nodosum presented itself; another evidence of the connection of influenza with rheumatism. Herpes labialis appeared in three cases, and zoster followed one of the most painful and prolonged attacks we have seen. This was in a plethoric man, fifty years of age, not of neuralgic habit.

Lumbago appears to be quite frequent as a sequel during the present week.

* * * * * *

So many instances of sudden death have been reported, that it would be of interest to know whether their number is really larger than in ordinary times. In their occurrence among persons apparently healthy, they resemble cases of this sort in cholera epidemics. A lady dropped dead last week in the waiting room of an illustrious Walnut street physician. One of the chief employés in a large Chestnut street store was seized with vertigo, went home, and died that night. Another man in the same store was similarly affected, fainted, and had to be taken home in a coupè; but recovered in a few days. Two other cases of the same sort occurred in a coal yard. All these were men under forty, hearty, and of good habits, not known to be affected by any organic ailment. Such occurrences in an epidemic of cholera or plague would be quoted as instances of the extreme virulence of the malady, or of maximum intensity of infection. But the influenza is not a disease of great virulence; and the present epidemic is rather mild in type.

Without having access to the precedent history of these cases, we can only give a surmise as to the cause of these sudden and fatal seizures; but this cause we believe to be home medication. Vast quantities of medicines are daily swallowed upon the advice of friends. Somebody remarks that "antipyrine is good for the grip," and the man who is somewhat nervous about his health, or is slightly affected with influenza, and yet is ashamed to acknowledge his fear by going to his doctor, accepts the suggestion, and runs in to the first drug store for some antipyrine. How much? Well, the clerk says Dr. Jones prescribes 10 grains every four hours; so he sells his customer a dozen powders of this size. But the customer has become imbued with the desire to make assurance doubly sure, and he proceeds to "knock it," by doubling the dose and repeating it at half the interval. The symptoms produced by this overdosing are very likely to be attributed to the disease, and the doses are thrown in still more freely in consequence. And thus an excellent remedy in the hands of those who know how to use it, becomes the cause of heart-failure and sudden death in the hands of ignorant meddlers.

But an equally pernicious idea is prevalent in the popularizing of the term "heart failure." It is on everybody's lips. Most men are nervous about their hearts. When one has learned the physiology of that wonderful organ, and how, sleeping or waking, it keeps up that pendulum-like beat whose stoppage is death, the fear that it may stop is pretty sure to arise. C : old Professor of Practice wound up a series of lectures on the heart by remarking that he believed he had examined the heart of every member of the class for suspected ailments. When this is the case with that wise individual, the medical student, we cannot wonder that, among the laity, nothing is more discomposing than the thought of heart failure, nor that amateur dosage with cardiac tonics should be indulged in. But digitalis, strychnine, and nitroglycerine are fearfully dangerous in ignorant hands; far more so than antipyrine. Coca and quinine are not drugs to be used indiscriminately, and the persons who advertise such remedies to the public take a very grave responsibility upon themselves.

* * * * * *

As even physicians are sometimes affected by the prevailing popular craze, we will append a few

DONT'S UPON LA GRIPPE.

Don't lose your wits and get to striking out wildly, but weigh well the conditions, and prescribe only with a definite object in view.

Don't be carried away by popular fancies, and give one drug for everything.

Don't go in with the determination to "knock it." This species of insanity is very prevalent just now.

Don't over-dose. The system of an influenza patient is highly susceptible to drugs of all kinds.

Don't give heavy doses of sedatives. The influenza is itself debilitating.

Don't give too much heart tonic. You may kill your patients thereby.

Don't forget that other diseases may be present during an influenza epidemic.

Don't forget that during an influenza epidemic its imprint is on every other disease.

Don't allow your patients to eat too little or too much.

Don't allow your patients too much alcohol.

Don't allow your patrons to dose themselves for any minor ailment during influenza.

Don't let your patients return to their business too soon.

Don't order more medicine than enough to last until your next visit. You will likely desire to change it somewhat, and it weakens the patient's confidence to see a medicine stopped when only partly used. It looks like indecision on your part.

Don't neglect the careful nutrition of your patient.

Don't let go your hold on your patient too quickly. Relapses and troublesome sequelæ, over-exertion and consequent collapse, are apt to follow.

Don't forget that a steady and persistent sustaining medication, carefully regulated by the effect on the heart, with the treatmeut of local symptoms, forms the only rational treatment of influenza.

Annotations.

SCARLATINA prevails in Philadelphia to some extent, the type being rather mild. In fact, it has been some years since the scarlatina in this city showed itself in a malignant manner. If it pleases our readers to have a "Scarlatina Number," we will prepare one. We hope that each one who is interested in the subject will forward us a concise account of the disease, as he has seen it. As THE TIMES AND REGISTER is pre-eminently a practitioner's journal, no material is as welcome to us as that which details the experience of practitioners.

DR. ACHILLES ROSE, of New York, says that he has taken baths in the river every winter for twelve years. On windy days he dries himself by walking up and down in the breeze. This procedure is not nearly as objectionable as it looks at first sight. Any one who begins daily bathing in mid-summer, will find that, as the water is but slightly colder on each successive morning, the body is gradually accustomed to the cold; and when the winter has set in, the cold bath leaves such a pleasant sensation that the practice will be continued from liking, apart from its beneficial action upon the health. To a person thus habituated to cold bathing, it is but a small step to open air bathing; and this has little unpleasantness to a man of robust health.

FIVE Assistant Medical Inspectors have been appointed by Director Beitler and the Board of Health. The duty of these inspectors is to visit the houses in which cases of contagious disease have been reported, and recommend such measures as will tend to prevent the spread of the disease. It seems incredible, when one considers the great extent of the city, and the number of cases reported, that any one man should have been expected to perform this task.

Letters to the Editor.

INFLUENZA.

I DESIRE to commend your method of devoting each issue of THE TIMES AND REGISTER to a special subject. You thus form a library of reference which must be of great value to the practitioner. I have long admired the plan in the *Deutsche Medizinal Zeitung*, which is, however, not so complete as your method, because the latter is chiefly made up of original and fresh contributions.

The perusal of the valuable and extremely practical articles in your last number brought to my mind a very general therapeutical error. Only two of your contributors referred to the value of opening the case with an active mercurial purge.

In my somewhat extensive experience, 6 to 10 grains of calomel, followed, if necessary, by Rochelle salts or other saline laxatives, has done more to relieve the pains and malaise of influenza than the coal-tar analgesics. Indeed, I have observed an abortive action, which precluded the necessity of my attending, as a rule, longer than three or four days.

The purgative is followed by six drops of diluted hydrochloric acid hourly in water, as a gastric antiseptic, and perhaps, also, as a placebo. I have rarely needed antiseptics or quinine.

Whether I have been fortunate in having milder cases to deal with or the treatment has been effective, I may say candidly that among a large number of cases in both epidemics, I have not seen a fatal case, and only three that gave me anxiety. Two of these cases came under my care late, being cases of consultation; the other was a physician who had treated himself for several days. All these terminated in broncho-pneumonia, and recovered after prolonged illness.

SIMON BARUCH, M.D.
67 W. SEVENTIETH STREET, N. Y.

Book Notices.

TEXT BOOK OF PRACTICAL ANATOMY. A Treatise on Practical Anatomy for Students of Anatomy and Surgery. By HENRY C. BOENNING, M.D., Lecturer on Anatomy and Surgery in the Philadelphia School of Anatomy. F. A. Davis, publisher, Philadelphia and London. 1891. Price, cloth or oil-cloth, $2.50, net.

The word "practical" is at the present time considerably misused. The utilitarian character of the age is shown by the various advertisements in which this word is displayed to attract attention and custom. Sometimes it comes in rather ludicrously, as in the sign of a certain blacksmith, which swings

above his smithy—"John Blank, Practical Blacksmith." A purely theoretical blacksmith has not yet confronted us. In connection with Dr. Boenning's book, however, the word practical is eminently proper, for it is a work that will prove satisfactory to the student at his dissecting table, or operative surgical work, without being inconveniently bulky.

The hundreds of students who have listened to the author's brilliant and instructive lectures on anatomy will be pleased to know of this valuable addition to the text-books on this subject, and to those who are entering on the study we can unhesitatingly recommend it as a guide and assistant to them in their difficult work.

The Medical Digest.

MORTALITY CAUSED BY WILD ANIMALS.—The mortality caused by wild animals in 1890 was considerably less than in the previous year, being a total of 2,460 against 2,724. The number of deaths in Bengal was 1,321; in the Central Provinces, 368; in the Northwest Provinces, 228; in Assam, 201; Madras, 196; and the Punjab only 31. Tigers and leopards accounted for the loss of 798 lives, and wolves 87. Returns, more or less doubtful, state that 64,500 cattle were destroyed by wild animals. A marked decrease has taken place in the number of wild animals destroyed, as the total for the year was only 14,604 against 17,638 in 1889. The amount paid as rewards in Madras fell off from Rs. 44,731 to Rs. 25,834. The total number of licenses held for this purpose was now 59,440. The total number of persons killed by snakes was 21,412 as compared with 22,480 in 1889; Bengal and the Northwest Provinces accounting respectively for 10,534 and 5,798 of these deaths. The number of snakes destroyed is returned as 510,659, of which four-fifths are said to have been killed in the Bombay Presidency.—*Indian Med. Gaz.*

CULTIVATION OF COCAINE.—It will, perhaps, be remembered that last year a suggestion was made by the authorities at home that an attempt should be made to manufacture hydrochlorate of cocaine at the cinchona factories in this country, on the score that the locally-produced drug would be less expensive than the imported article. Experiments were sanctioned for Bengal, but in Madras the authorities determined not to undertake any, as the demand for the drug was very small. We now learn, from a recent report, that *Erythorxylon coca*, the plant which yields the drug, has been cultivated for many years in several parts of the Madras Presidency. It grows like a weed, and the yield of cocaine from the leaves is said to be fully equal to that obtained from the American shrub. Should there be, therefore, at any time a larger demand for this alkaloid, it is said that in Southern India, at any rate, there would be no difficulty in obtaining a very large amount of the leaves. The Government Botanist, who reports on the matter, is, however, doubtful whether, with the prices now ruling in market, it would pay the planter to cultivate the plant in any large quantities.

—*Indian Med. Gaz.*

CAMPHORIC ACID IN PHTHISIS AND IN CYSTITIS.—Camphoric acid has been employed in cystitis, and as an intestinal disinfectant, by Fürbringer; it has also been used with success in the treatment of the night-sweats of phthisis. More recently Bohland has been employing this drug, of which he gives one gramme in a wafer at nine or ten o'clock at night. The dose may be increased to two grammes, or even to three grammes if necessary; for some patients who only begin to perspire towards the morning it may be well to administer the camphoric acid at two or three o'clock in the morning. The results he obtained were satisfactory in about 80 per cent. of the cases. Camphorate of soda appears to have an action somewhat inferior to that of camphoric acid. In two cases the acid, given in the dose of three grammes in three doses, arrested phthisical diarrhœa which had resisted other methods of treatment. In cystitis when the urine is ammoniacal and alkaline it can be speedily cleared and rendered acid by three grammes of camphoric acid in the day, given in three doses. The acid is eliminated with the urine from two to five hours after its administration. Urine thus impregnated with camphoric acid may be kept several days without undergoing putrefaction.

IMPROVEMENTS IN THE MANUFACTURE OF ALUMINUM.—The Thowless Aluminum Works, Newark, N. J., have lately begun operations in the production of aluminum, under the process of Mr. Orlando M. Thowless. The success of the trials of the new method gives rise to the expectation that a new industry has been permanently established, which will rapidly assume great and important proportions.

By the new process the inventor makes metallic sodium from caustic soda, and makes it so cheap that it can be sold for seven cents per pound, while it has so far sold for $1 per pound. In making the aluminum, the new process takes a quantity of caustic soda, and while it is in a heated state it is passed into a retort made of iron, and which has been previously charged with carbon, either in the form of gas retort carbon or commercial charcoal. An immediate disassociation takes place, forming a sodium vapor, which is allowed to pass off through a conducting pipe, and this vapor, as it condenses, forms the metallic sodium. In the next state in the process the aluminum material, which is cryolite or bauxite, and preferably the latter, is melted in clay crucibles until it is a bright red, when the metallic sodium is placed at the end of a long iron hook and dipped and stirred in the hot molten material until it has been melted too, and made part of the heated mass.

A rapid chemical action is the result, in which the aluminum is formed in the crucible, and after it is decanted into cold iron pots, the light metal rises to the top, and when cool it is separated and then recast into any desired shape or form.—*Scientific American.*

INFLUENZA.—The medical department in the Prussian war office has published a book on the influenza epidemic of 1889–90 in the German army. The number of cases was 8,778, and the epidemic spread from northeast to southwest. The book contains highly convincing proofs of the infectious character of the disease. It is copiously illustrated, and treats also of the causes, treatment, and prophylaxis of the disease. On December 17, Prof. Nothnagel, of Vienna, lectured to his students on influenza. After expatiating on the history of influenza and its dissemination this year, he continued as follows: "The following questions of general interest arise. How far is one protected in influenza against relapses? Does one attack confer immunity or not? Does it leave the patient more predisposed for a second attack or less? From

the observations hitherto made one may say that one attack does not increase the predisposition; whether it diminishes it will perhaps now appear; but here, too, one must say, 'Non liquet.' One thing is clear—influenza is an infectious disease. Despite all bacteriological investigations, the specific agent of influenza is unknown, we have a great chaos before us, but no clearness. One thing is beyond doubt: Influenza may certainly be miasmatic, for it was observed that the epidemic spread at a rate much more rapid than that of human intercourse. As regards the symptoms, we adhere to the old classification, and distinguish between nervous, gastric, and catarrhal influenza. The virus of influenza shares with many other microbes the quality that it infects and affects the whole body; the most various parts of the frame may suffer from it. It has struck observers from of old that the fatal cases of influenza are mostly those in which the organs of respiration are affected. Slight croupy pneumonia may occur in influenza and along with it. Apart from this, however, there is a genuine influenza pneumonia which, owing to its severe effect on the heart, is more dangerous than bronchial pneumonia. The prognosis is very various. Weak persons, and those who suffer from heart disease or tuberculosis, seem to be exposed to greater dangers than others." In conclusion, Professor Nothnagel spoke of the treatment of the disease, declaring that there is no specific against it, and the treatment must be symptomatic, and most decidedly warning against all experiments with antipyrin and antifebrin. In the week which ended on December 12 the number of deaths in Berlin from influenza was eighty.—*Lancet.*

DETACHMENT OF RETINA.—The first case was a young man, with previous history of injury to one eye, in whom the detachment occupied about one-third of the fundus. The injection caused very little reaction; but the primary effect was a diminution of the existing visual acuity. Subsequently the vision improved and the field widened. Plastic choroiretinitis causing adhesion to the retina to choroid was undoubtedly the cause of this; but the formation of additional fibrous bands in the vitreous will probably lead to a further increase of the detachment, and probably to permanent loss of vision.

The second case was a young woman, with hypermetropia and a perfectly normal fundus in one eye; but with a cobweb membrane and a detachment of the retina in the other, occupying about one-third of the fundus. The injection caused a somewhat more violent reaction than in the first case; but soon subsided under active treatment. The effect of the operation was to make the vision decidedly worse, and cause no diminution of the detachment, but simply shifted it from one quadrant of the eye to another quadrant. Rather extensive plastic chorio-retinitis, and the formation of fibrous bands in the vitreous were decidedly bad results.

The third case was a gentleman, aged sixty, who had compound myopic astigmatism and a diseased choroid in both eyes, with detachment of the retina in one eye. The injection caused acute infectious panophthalmitis, which ended in nearly total destruction of vision in this eye, and an apparent increase in the extent of the detachment, though this could not with certainty be made out.

The fourth case was a gentleman, aged seventy-three, who had myopia and diffuse choroidal disease in both eyes, and a very extensive detachment in one eye. The injection caused an acute panophthalmitis of moderately severe type, which yielded to treatment in about two weeks. The primary effect was an improvement in the vision and a decided lessening in the extent of the detachment, more than half of the detached portion becoming reattached. But the ultimate effect was a recurrence of the detachment and a reduction of the vision to what it was before the operation was done, and subsequently an opacity of the lens.

The fifth case was a gentleman, aged thirty-six, with compound hypermetropic astigmatism and a diseased fundus in both eyes, and a small detachment of the retina in one eye. The injection caused only moderate reaction. The primary effect was an increase in the detachment and a further loss of vision, but subsequently the retina became reattached at the inner quadrant and detached below, and vision rose to $\frac{15}{200}$. Two months later his vision had again sunk to $\frac{6}{200}$, and the detachment of the retina had become more extensive.—C. S. Bull, *Med. Record.*

UNSUSPECTED HEART-DISEASE.—Sir Andrew Clark reported 864 cases which he had seen suffering from chronic valvular disease of the heart, "which was not indicated by symptoms, and had not sensibly interfered with the health."

Every practitioner must have been struck with the occasional appearance among his patients of similar cases; and I venture to report some which have lately occured to me, with the purpose, not so much of endeavoring to establish a fact already well known, as to enforce its practical bearing. In my cases, the patient had no idea of cardiac trouble, and indeed, some of them were such that the physician would not be led by the rational signs to regard organic heart-disease as the most probable diagnosis.

CASE I.—Mr. I. W. H., aged fifty one, was a retired business man, who used very strong tobacco to excess. He described himself as a "tobacco worm." This gentleman was fond of an out-door life, and in October, 1889, while making a "carry" in the woods with a rather heavy load upon his back, he experienced a sudden pain in the jaws, severe enough to make him stop, whereupon the pain ceased; but it recurred when he resumed his march. From that time to the time when I first saw him, seven months later, the pain was felt upon either excitement or exertion; and there had been added to it a palpitation of the heart. The double aortic lesion which was found upon examination, had not, in any way, interfered with his pleasures or exertions until the time when this neuralgic pain first appeared.

CASE II.—Mr. C. G., aged thirty-three, a contractor, experienced an accidental injury for which he was brought into the Massachusetts General Hospital, November, 1890, coming under the care of Dr. C. B. Porter, who kindly permits my mention of the case. Physical examination revealed, beside his surgical injuries, slight lateral enlargement of the heart, with a systolic apex murmur transmitted into the axilla, and a to-and-fro murmur in the second interspace on the left. In this case, no symptoms had pointed to the heart. But for the accident, it is not probable that the patient would have come under medical observation.

CASE III.—J. R., aged nineteen, fell down stairs and injured his right ankle ten days before he called upon me. He was confined to bed for nine days, but, on arising, he noticed trouble about the heart, having never had such symptoms before. He came to me supposing that the fall had caused heart-disease. On investigation, it was found there was no history of rheumatism or scarlet fever; but the patient had had

small-pox when a child. The heart's apex was in the fifth space outside of the nipple. There was enlargement of the heart a finger's breadth to the right of the sternum, presystolic thrill at the apex, a presystolic and systolic apex murmur, and a double murmur over the aortic region, with a typical "crural tone" in the femoral artery—a condition of things evidently chronic.

CASE IV.—(Reported by the kind permission of Dr. Shattuck.) Mr. H., aged thirty-four, a gardener, complains of purpuric spots, and pain in the muscles of the legs. Otherwise he feels perfectly well and looks well, and his bodily functions are well performed. Examination, however, reveals a systolic thrill at the heart's apex, and a loud systolic murmur heard best in the fourth space on the left, but audible all over and even outside of the cardiac area. The pulmonic second sound is not accentuated, nor is the heart much enlarged. The murmur, which is sometimes rough in character, has persisted now for several months, and is, in all prabability, due to mitral regurgitation well compensated.

CASE V.—(Also reported by permission of Dr. F. C. Shattuck). Herbert F., aged twenty-one, a farmer, had acute articular rheumatism four years ago; but, after recovery from that, he had done hard work and enjoyed excellent health until three days before entrance into the hospital, with the symptoms of subacute rheumatism. Examination established clearly the existence of mitral regurgitation, referable not to the present, but to the first attack of rheumatism.

CASE VI.—(Reported by the courtesy of Dr. H. C. Ernst). D. O'G., aged twenty-six, teamster, comes to the out-patient department of the Massachusetts General Hospital, on account of an eruption of secondary spyhilis. Although, on questioning, he states that he had, some years previously, undergone an attack of rheumatism which confined him to the bed, and, for the last three or four months, has had some dyspnœa on exertion, he maintains that the only symptoms which led him to seek advice are connected with his venereal trouble. Examination shows an enlarged heart with a distinct presystolic thrill and presystolic murmur at the apex, and accentuation of the pulmonic second—mitral stenosis.

CASE VII.—(Reported also by permission of Dr. Ernst). William D., aged twenty-six, a butcher, complains of "pain in the kidneys," great thirst, cramps and dull aching pain through the legs at night; excessive appetite, frequent micturition and loss of twenty-two pounds weight. On later inquiry, he acknowledges that four years ago, he had an attack of acute articular rheumatism lasting three months, but he has never noticed any cardiac symptoms. This patient was brought to the medical clinic at the hospital as a case of diabetes mellitus, and with good reason; but the prominent pulsation of the temporal arteries in so young a man (twenty-six years), called attention to the heart, which was found to be hypertrophied and affected by both aortic and mitral incompetence.

CASE VIII.—N. S., aged seventeen, was in the Massachusetts General Hospital, November 13th to December 29, 1890, with uræmia; and, on examination, he was found also to be suffering from mitral regurgitation. In May, 1891, and again in October, 1891, the patient returned for observation, and no complaint of cardiac symptoms could be elicited, although the objective evidence of the heart lesion was still present.

CASE IX.—John D., aged twenty-two, a waiter, had rheumatic fever four years ago. The reason for his seeking advice, in May, 1891, I have forgotton; but I am confident that it was no direct cardiac symptom. He had been ailing only two weeks. On examination, a double mitral lesion, with a thrill at the apex, and an aortic regurgitation, were made out, and there were also moist râles above the right clavicle.

CASE X.—William M., aged forty, complained that for one week he had experienced cough and pain in the chest. No other symptoms could be elicited. Examination disclosed moist râles in both bases behind, also a double aortic murmur and a systolic murmur at the apex transmitted into the axilla.

CASE XI.—F. S., aged fifty-six, paper-hanger, has had a cough all winter, with little expectoration, and he also suffers from "sour stomach." The heart is irregular in action and the aortic valve is incompetent.

CASE XII.—Daniel S., aged seventy-two, complains of "being sore all over" and "choked up in the chest." He coughs all night, with a mucus expectoration. Bread and tea are the chief diet. The pulse is irregular, feeble and intermittent. There is a faint systolic murmur at the apex, transmitted towards the axilla. Pulmonary œdema exists at the bases of both lungs.

Of these twelve patients, five had diseases of both the aortic and mitral valves, four had mitral regurgitation, one had mitral stenosis, one had aortic regurgitation, and one had both stenosis and incompetence of the aortic valves. Of the 684 cases reported by Sir Andrew Clark, 41 per cent. had mitral regurgitation, 24+ per cent. had aortic stenosis, 14 per cent. had affections of both valves, 9 per cent. had mitral stenosis, 4½ per cent. aortic regurgitation, 3½ per cent. aortic obstruction and regurgitation, and 2½ per cent. mitral obstruction and regurgitation.

According to his experience, therefore, we might infer that mitral regurgitation is the least unfavorable valvular disease, and next to it, aortic stenosis; but different authorities differ widely about this question. Fagge regards aortic stenosis as of the least relative importance, followed by mitral stenosis, next to which—but separated by a long interval—comes mitral regurgitation and aortic regurgitation. Strümpell believes that aortic regurgitation generally gives the best prognosis, that mitral insufficiency is rather worse, and that worst of all are mitral stenosis and aortic stenosis.

If we search for an explanation of these apparent contradictions, we shall find it in the all important fact that every case of heart-disease must be judged independently. The crucial test for the heart is its ability to carry on the circulation. Now it is easy to see that the size of the leak or the degree of the stenosis may vary between great extremes, that the development of compensatory hypertrophy may be ample in a young and robust individual of good habits, and next to nothing in an old and spyhilitic drunkard, and that a stationary lesion which presents no changes in the course of one or more years, is less to be feared than one which is still progressive. The names mitral stenosis, aortic regurgitation, and the like, tell only a part of the truth, and that not the most important. Myocardial degeneration without a murmur is a worse thing than valvular lesion with adequate hypertrophy. And although I do not here present such a case, the determination of the state of the cardiac muscle demands even more vigilance in physicial examination than the condition of the valves. It should be added, perhaps, to avoid mis-

understanding, that given a defect in the valves, the degree of cardiac hypertrophy is, to some extent, a measure of the importance of that defect. If compensation is good, the less the hypertrophy, the more favorable the case.

The twelve cases reported by me had this one thing in common: for a considerable period of time they had had heart-disease, and yet, had been entirely unconscious of the fact. Some of them, indeed, did not have symptoms suggesting heart-disease to a physician, thus affording a striking contrast to the sufferers from functional disorders who so frequently demand a physical examination and who are so slow to be convinced that their hearts are not organically diseased.

The ordinary rational signs of heart-disease may be briefly enumerated as follows: dyspnœa, palpitation, precardial distress, headache, vertigo, cough and indigestion. Of my cases, one, it will be remembered, confessed on questioning that he had suffered somewhat from dyspnœa, although he asserted that the trouble was very slight. With this exception, none of the patients presented the rational symptoms just enumerated, except cough (which was present in three cases) and indigestion (which was present in one case).

Of Clark's 684 cases, 402 had digestive symptoms, 35 had headache, 17 had vertigo, 23 had bronchitis, and 7 had pulmonary congestion; so that really 487 might be said to have presented symptoms suggesting the possibility of cardiac disease; but even then, the large number of 197 remain, the correct diagnosis and proper treatment of which hung upon the physicial examination.

The lesson to be gained from these observations is the necessity of thoroughness in the physical examination of every patient, so far as practicable. There are those who regard it a mistake to inform a patient, as yet undisturbed by cardiac symptoms, that he is the victim of a cardiac disease. Bristowe, for example, speaking in this connection, says: "I am sometimes inclined to think it is a pity there are physicians. Many persons would lead a happy life enough but for them. If a patient has heart-trouble, he does not wish to learn the fact." My own view is that, under ordinary circumstances, the earlier such a discovery is made by the physician and communicated to the patient, the better. This affords a fair chance for averting cardiac failure. A sensible patient, properly advised as to his physical limitations, may be able to lead a long, happy and useful life, whereas, unwarned, he might soon collapse into hopeless invalidism.—Vickery, *Boston Med. and Surg. Journal.*

GERMAN NOTES.

HERMAN D. MARCUS, M.D.

THILANIN.—Dr. Edmund Saalfeld (Berlin), describes a preparation of brown sulphurated lanoline —thilanin.

Thilanin has the same consistency as lanoline, is of a yellow-brown color, smells like sulphur, of which it contains 33 per cent. This compound replaces Hebra's ointment—borvaseline or borlanoline —in the treatment of superficial skin diseases. It was used in a number of cases of eczema, never producing any irritation. Three cases of acute eczema of the face were cured in three days. A case of subacute, dry facial eczema was cured in a remarkable short time. Following is a report of cases cured by the use of thilanine:

Two cases of eczema rhagadiforme scroti et penis;

Three cases of herpes zoster;

A number of cases of sycosis vulgaris, eczema in children (especially of the head);

Five cases of chronic eczema confined to hand and legs.

The use of the undiluted thilanin on the hairy scalp is contraindicated.—*Therap. Monatshefte.*

A CASE OF POISONING THROUGH DERMATOL.—Dr. Weismueller, reports the following: I. V., thirty-eight years old, had ulcus crucis on both legs for some years. He was under treatment with many physicians, who prescribed mostly internal remedies (sulphur, arsenic, etc.). He finally applied to me. Each leg showed two large ulcers, which were painful and accompanied by secretions. I applied ℈iv dermatol with bandage, and recommended rest. Two days later I changed the dressing, and as no improvement was noticeable and the dressing was very wet, I again dusted dermatol on the wounds. After using 5–8 drachms dermatol in ten to twelve days, no improvement was noticeable. Patient complained of vertigo and itching. At his request to prescribe something else, I gave him a powder to dust over parts, consisting of

℞.—Acid. salicyl.	℈iv.
Acid. borici	℈ij.
Zinci oxid	℥ss.
Amyl.	
Talc	āā ℥v.

This powder I have used for one and one-half years with excellent results in ulcus crucis, and I can claim that no treatment, except the Thiersch transplantation, can equal this treatment. In three weeks the left leg was entirely healed and the right wound began to granulate..

Mrs. Sch. had ulcus crucis on the left leg for two years. Much pain and secreting largely. I prescribed ʒiij dermatol to be dusted over the very large ulcer. After three days, I found patient in bed, being unable to walk on account of excessive pain. Patient showed fever (102.5°), complained of headache, malaise, anorexia, and had over the whole body an itching and burning eruption. On the foot I found bullæ filled with serum. I discontinued the dermatol and prescribed my powder (as above). After two days the eruption was diminished, the burning had disappeared. After four more days, patient was able to attend to her business; after eight days, patient was cured.

The same results as above followed the use of dermatol in five more cases of chronic leg ulcer.

I came to the following conclusions:

1. Dermatol cannot supplant iodoform;
2. In fresh wounds dermatol does not act as prompt as iodoform;
3. The antiseptic properties of dermatol are not as great as these of iodoform;
4. Iodoform in powder dries wounds as well, if not better, than dermatol.

—*Berliner Klin. Wochenschrift.*

ANOTHER LOCAL ANÆSTHETIC.—Dr. E. Staver recommends the following local anæsthetic for minor operations:

℞.—Cocaine	gr. v.
Antipyrin	gr. xv.
Aquæ	gr. c.

It is claimed that this anæsthetic acts longer and with more intensity than cocaine alone. The same mixture was used with success in a case of obstinate vomiting.—*Deutsche Medizinal Zeitung.*

DIPHTHERIA.—Dr. Radwansky recommends the following treatment for diphtheria in small children:

One teaspoonful of a 1 per cent. chlorate of potash solution every hour, locally four times daily, washing out of the oral and pharyngeal cavities with a ½ per cent. salt solution, and morning and evening powdering of the parts with a mixture of 15 grains iodoform and two and a half drachms of bicarbonate of soda with an insufflator. He also recommends the use of a 3 per cent. carbolic acid solution as a disinfectant (spraying) near the bed every hour.

For older children and adults he uses a tablespoonful of a 1 per cent. to 3 per cent. chlorate of potash solution every hour; otherwise proceed the same as above. According to the age, he lets the patient inhale hourly a 1 per cent. to 3 per cent. carbolic acid solution, and if the patient can gargle he prescribes as a gargle every two hours a 3 per cent. boracic acid solution. Finally, Priessnitz's compresses on the throat, to be changed every, hour if fever is high; also on the thorax. After two to three days he claims that the diphtheritic membrane disappears.

—*Der Ærtzl. Practiker.*

LOCAL ANÆSTHESIA.—Dr. Dòbisch recommends the following mixture as a local anæsthetic:

℞.—Mentholi..... gr. xv.
Ether sulph..... ℈ iv.
Chloroformi..... ℥iij, ℈v.

This mixture may be used for small operations, and is to be applied with the Richardson's spray. The parts can be quickly anæsthetized and kept in this condition for from two to six minutes. It is highly recommended in the division of a fistulous tract.

—*Deutsche Medizinal Zeitung.*

DERMATOL.—Dermatol has been used in Dr. von Rogner's clinic, at the Wieden Hospital in Vienna, as the *only* dry antiseptic, in place of iodoform for six weeks. All kinds of wounds were thus treated—fresh, suppurating, and septic; also, extensive phlegmonæ, burns, etc.

Dermatol was used—

1. Pure, as dusting powder;
2. As ointment, as follows:

℞.—Dermatoli..... ℥v.
Vaselin. flav..... ℥xx.
M.—Ungt.

3. In collodion emulsion:

℞.—Dermatoli..... ℥iij.
Collod..... ℥iij.
M.—Use locally.

4. As 10–20 per cent. gauze.

Superficial, not extensive, suppurating wounds should be dusted thin. Extensive suppurating wounds must be covered by a large amount of the powder. Abscesses, phlegmonæ, etc., should be washed with an antiseptic solution (sublimate), dead tissues must be removed, and then can dermatol be applied.

Dermatol proved itself an excellent astringent remedy, with a tendency to reduce secretions. Small superficial wounds healed soon, while large operating wounds healed by first intention.

Poisoning was never observed. Von Rogner calls dermatol the best dry antiseptic, and prefers it to iodoform.—*Internat. Klin. Rundschau.*

Medical News and Miscellany.

CAMDEN CITY MEDICAL SOCIETY.—At the annual meeting of the Camden City Medical Society held January 14, the following officers were elected: President, Alexander McAlister; Vice-President, Geo. T. Robinson; Secretary, Joseph H. Wills; Treasurer, George Taylor Robinson; Managers of the Camden City Dispensary, Drs. H. G Taylor, A. M. Mecray, E. L. B. Godfrey, Dowling Benjamin, W. A. Davis, H. A. Davis, O. B. Gross, and E. P. Townsend.

RT. REV. PHILLIPS BROOKS, of Massachusetts, is the subject of a portrait and biographical sketch in the January *Book News* (Philadelphia). Perhaps in no other city has the newly appointed bishop so many warm friends and admirers as in the city where first were recognized his power as a preacher, and his sterling qualities as a teacher and leader in his church. The volumes of his published sermons mark his influence beyond the pulpit, and his beautiful "Easter Carol" has a legion of lovers.

DR. DANIEL AYRES, the well known Brooklyn physician, who aided in the organization of the Long Island College Hospital and the Brooklyn Hospital, and who gave $275,000 to Wesleyan University, and $10,000 to the Hoagland Laboratory, died this week, aged seventy years. For over forty years he has been one of the leading physicians of Brooklyn. He graduated at Princeton, and studied medicine with Dr. Valentine Mott. He filled many responsible positions in the line of his profession, and wrote many valuable articles for the medical journals. He made several important discoveries in surgery. He was made a Doctor of Laws by Wesleyan University. He leaves a widow and two sons, both physicians.

WEEKLY Report of Interments in Philadelphia, from January 9 to January 16, 1891:

CAUSES OF DEATH.	Adults.	Minors.	CAUSES OF DEATH.	Minors.	Adults.
Abscess	1	1	Inflammation bladder	1	
Aneurism of the aorta	3		" brain	2	10
Apoplexy	16		" bronchi	7	12
Asthma	3		" kidneys	4	2
Bright's disease	10		" larynx		1
Burns and scalds	1		" tonsils		1
Cancer	8		" lungs	58	33
Casualties	7		" pericardium		1
Congestion of the brain	2	7	" peritoneum	3	
" " lungs	8	4	" s. & bowels	7	4
Childbirth	2		" spine	1	
Cholera morbus		1	" spleen	1	
Cirrhosis of the liver	3		Locomotor ataxia	1	
Colic		1	Malformation		1
Consumption of the lungs	56	5	Marasmus		15
Convulsions	1	18	Measles		2
Croup		11	Neuralgia of the heart	1	
Cyanosis		2	Obstruction of the bowels	1	
Debility	2	6	Old age	23	
Diabetes	2		Pemphigus		1
Diphtheria	1	31	Paralysis	9	
Disease of the heart	24	10	Poisoning, carbolic acid	1	
Dropsy	1	1	Pyæmia	1	2
Dysentery	1	1	Septicæmia	2	
Epilepsy	1	1	Softening of the brain	6	
Erysipelas	1	1	Suffocation		1
Enlargement of the heart	2		Suicide	1	
Emphysema	1		Syphilis		2
Fatty degeneration of the heart	2		Teething		1
Fever, catarrhal	1		Tumor	2	
" puerperal	1		Ulceration of the stomach	1	
" scarlet		19	Uræmia	4	
" typhoid	14	6	Whooping cough		2
Inanition	1	9			
Influenza	42	7	Total	355	233

THE INTERNATIONAL EXECUTIVE COMMITTEE OF THE PAN-AMERICAN MEDICAL CONGRESS.—The Committee on Organization of the Pan-American Medical Congress at its meeting at St. Louis last

October, elected the following Inter-national Executive Committee: The Argentine Republic, Dr. Pedro Lagleyze, Buenos Aires; Bolivia, Dr. Emelio Di Fomassi, La Paz; Brazil, Dr. Carles Costa, Rio de Janeiro; British North America, Dr. Jas. F. W. Ross, Toronto; British West Indies, Dr. James A. De Wolf, Port of Spain; Chili, Dr. Moises Amarat, Santiago; United States of Colombia, Dr. P. M. Ibañez, Bogota; Costa Rica, Dr. Daniel Nuñez, San José; Ecuador, Dr. Ricarda Cucalon, Guayaquil; Guatemala, Dr. José Monteris, Guatemala Nueva; Haiti, Dr. D. Lamothe, Port au Prince; Spanish Honduras, Dr. George Bernhardt, Tegucigalpa; Mexico, Dr. Tomás Noriega, City of Mexico; Nicaragua, Dr. J. I. Urtecho, Grenada; Peru, Dr. J. Casamira Ulloa, Lima; Salvador, Dr. David J. Guzman, San Salvador; Spanish West Indies, Dr. Juan Santos Fernandez, Habana; United States, Dr. A. Vander Veer, Albany, N. Y.; Uruguay, Dr. Jacinto De Leon, Montevideo; Venezuela, Dr. Elias Rodenguez. Caracas.

Hawaii, Paraguay, Santo Domingo, the Danish, Dutch and French West Indies are not yet organized. Nominations of local officers have been received from a majority of all the members of the International Executive Committee, and a number of the lists have been confirmed by the Committee on Organization. These will be announced as rapidly as acceptances are received.

CHARLES A. L. REED,
Secretary General.

THE use of bye-products from factories of various kinds is constantly on the increase. Glycerin was first obtained as a waste from soap factories, while the coal-tar bye-products furnish us with all the aniline dyes; now the breweries promise to supply liquid carbon dioxide at about one sixth of the present price. Thus the beer factory can turn out the alcoholic beverage for those who prefer it and draw soda-water to quench the thirst of the prohibitionists.

—*Meyers' Druggist.*

CAMDEN CITY DISPENSARY.—The new building of the Camden City (N. J.) Dispensary was formally opened to the public, on January 9, with appropriate ceremonies. Among the speakers was Hon. Henry Bonsall, editor of the *Post*, who read the following poem:

In holy shrine and temple fane
We here assemble once again
To herald on the trump of fame,
The Doctors.

As here the Medicos we meet,
And learn new wisdom at the feet
Of those whom we are proud to meet,
The Doctors.

Magicians who our ills assuage,
Who take our pulse and even gauge
Our temperature when fevers rage,
The Doctors.

Who mitigate our many woes,
And patch us up from scalp to toes
With porous plasters 'stead of clothes,
The Doctors.

Who fill our craws with coated pills,
And nasty draughts the de'il distills,
And for it sends us swingeing bills,
The Doctors.

For which they oft our censure earn
As with indignant spleen we burn,
But to them we are forced to turn,
The Doctors.

Who like the fishes swim in schools,
Scoffing at all the paltry fools
Who disregard conventional rules,
The Doctors.

And to this day they can't agree
On tweedle-dum and tweedle-dee,
But all unite upon the—fee,
The Doctors.

Yet when we feel we're getting sick
We send for M.D.'s p.d. quick,
According them the winning trick,
The Doctors.

For when we're in the grip's fell clutch
We're not so proud—not overmuch,
But reach out for the only crutch,
The Doctors.

So, when dread anguish wrings the brow
Without reserve we all allow,
"A ministering angel thou,"
The Doctor.

And in the hour of sore distress
The rich and poor alike express
Their fervent thanks and say "God bless
The Doctor."

For no respecter of persons he,
Nor purse, nor place, as all agree,
He fighteth for the victory,
This Doctor.

The victory o'er disease and death,
This of his nostrils is the breath,
"This is my mission" answereth
The Doctor.

And many dollars doth he lose,
And many men do him abuse,
Then let's commend to tuneful muse
This Doctor.

The muse recounteth knightly skill,
Then let the muse this truth instill
And credit pay, and pay the bill
Of the indispensable Doctor.

Army, Navy & Marine Hospital Service.

Changes in the Medical Corps of the U. S. Navy for the week ending January 16, 1892.

PARKER, J., Surgeon. Ordered to the U. S. S. "Charleston."

WHITE, C. H, Medical Inspector. Detached from U. S. S. "Charleston," and ordered home.

LUNG, GEORGE A., Assistant-Surgeon. Ordered to examination for promotion.

BRYANT, PATRICK H., Assistant-Surgeon. Ordered to examination for promotion.

VON WEDEKIND, LUTHER L., Assistant-Surgeon. Ordered to examination for promotion.

THE KELSEY ORIENTAL BATH CO., LIMITED.

H. W. KELSEY, Manager,

Turkish and Russian Baths.

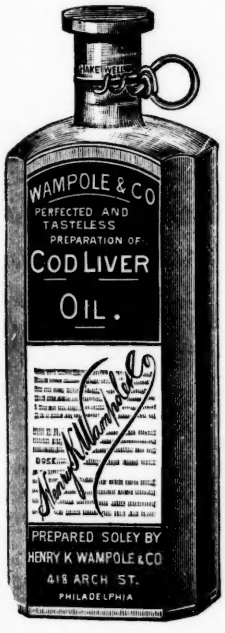
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FOR LADIES, 9 A. M. TO 6 P. M., WEEK DAYS ONLY.

Single Baths, $1.00; 7 Tickets, $5.00; 15 Tickets, $10.00.

Wampole's Perfected and Tasteless Preparation of Cod-Liver Oil.



Combined with Extract of Malt, Fluid Extract of Wild Cherry Bark and Syrup Hypophosphites Compound (containing Lime, Soda, Potassium Iron, Manganese, Quinine, and Strychnia).

Containing the curative agents from 25 per cent. Pure Norwegian Cod-Liver Oil. Rendered pleasant and agreeable by the addition of choice Aromatics. For full directions, see circular surrounding bottle.

We invite your attention to the "fac simile" of an Analysis made by Charles M. Cresson, M.D., certifying to the value and efficacy of this Preparation, and which we have printed on the back of our circular.

NUTRITIVE. TONIC. STIMULANT.

Put up in 16-ounce bottles, full measure, $8.00 per dozen, net.

Put up in 5-pint bottles for convenience in dispensing, and as a regular stock bottle. 5-pint bottles, each $3.00, net.

Wampole's Concentrated Extract of Malt	$2.00 per doz.
" Syrup Hypophosphites Compound . . .	$3.50 per 5-pint bottle.
" " Hydriodic Acid	$8.00 per doz. in lb. bottles.
" Granular Effervescent Salts.	

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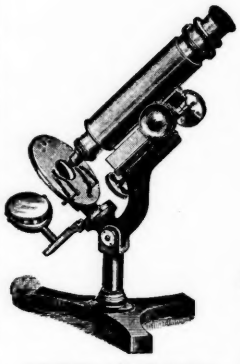
THE BOARD OF LADY MANAGERS OF THE COLUMBIAN EXPOSITION.—The participation of women in the Exposition promises to be one of its most interesting as well as novel features. With a commodious and imposing building, designed by a young lady architect, and with an abundance of money and with full recognition, indorsement, and aid by the United States Government, and the Exposition Directory, the women have an opportunity of showing in most signal manner, the condition of their sex throughout the world, what are the achievements of woman in the various branches of human endeavor, and what is her adaptability to different occupations and lines of industrial and charitable work. Under the direction of the Board's president—Mrs. Potter Palmer—the work of organization, and of enlisting the interest of women throughout the United States and in foreign countries, has progressed to a most satisfactory stage.

To supply the Columbian Exposition buildings and grounds with water two plants are being put in, one with capacity of 24,000,000 gallons a day, and the other of 40,000,000 gallons. Thus 64,000,000 gallons a day will be available. The pumping works and all the great machinery furnishing power to the Exposition will be open to the inspection of visitors.

A system of drainage, believed to be adequate and perfect, has been adopted. Perfect sewerage, too, is planned. All refuse from the cafés and kitchens, and from the lavatories and closets, of which 6,500 will be constructed at an expense of some $450,000, will be received by injectors, and forced by compressed air through underground pipes into four huge tanks, where it will be treated chemically and rendered entirely inoffensive. Work upon these systems is progressing.

Plans adopted for lighting the buildings and grounds provide for 138,218 electric lamps, of which 6,766 are to be arc lamps of 2,000 candle power each, and 131,452 incandescent, 16 candle power each. The electric lighting will cost something like $1,500,000, and will be ten times as extensive as was employed at the Paris Exposition. The light and motive plant at the Exposition, it is estimated, will require 26,000 horse power, of which 22,000 will be required for the electric plant.

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Kumysgen when prepared for use contains every constituent of a perfect Kumyss.

Kumysgen is made from fresh, sweet milk, and contains fully thirty per cent. of soluble casein, which is double the amount found in ordinary Kumyss preparations.

Kumysgen being in Tablet form, will keep indefinitely, is easily and readily prepared, less expensive than the ordinary variable and perishable Kumyss, and its *fermentative action* may be regulated at will, thus rendering it available at all times and under all circumstances.

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